DOCUMENT RESUME

ED 325 786 CG 022 943

TITLE Law and Policy Affecting Addicted Women and Their Children. Hearing before the Select Committee on Children, Youth, and Families. House of Representatives, One Hundred First Congress, Second Session.

INSTITUTION Congress of the U.S., Washington, DC. House Select Committee on Children, Youth, and Families.

PUB DATE 17 May 90

NOTE 332p.

AVAILABLE FROM Superintendent of Documents, Congressional Sales Office, U.S. Government Printing Office, Washington, DC 20402.

PUB TYPE Legal/Legislative/Regulatory Materials (090)

EDRS PRICE MF01/PC14 Plus Postage.

DESCRIPTORS Children; *Child Welfare; *Drug Addiction; *Federal Legislation; Hearings; *Mothers; *Perinatal Influences; Pregnancy; Public Policy; State Legislation

IDENTIFIERS Congress 101st

ABSTRACT

This document contains the text of a one of a series of Congressional hearings called to examine substance abuse among pregnant and parenting women and to explore prevention and treatment strategies. This hearing focuses on federal and state policies designed to address the urgency of perinatal substance abuse. Witnesses provide testimony on state legislative legal remedies and explain what the federal government can do to help. Opening statements are provided by George Miller, Chairman of the Select Committee on Children, Youth, and Families, and by Representative Bliley (prepared statement). Witnesses providing testimony include: (1) Susan Galbraith, director, Coalition on Alcohol and Drug Dependent Women and Their Children; (2) David Gates, staff attorney, National Health Law Program, Inc.; (3) Neal Halfon, director, Center for the Vulnerable Child, Children's Hospital in Oakland and assistant clinical professor of pediatrics and health policy, Department of Pediatrics and Institute for Health Policy Studies, University of California at San Francisco; (4) Jo Ann Kauffman, president, National Association for Native American Children of Alcoholics; (5) Kary Moss, staff attorney, Women's Rights Project, American Civil Liberties Union; (6) Albert Pruitt, chairman, Department of Pediatrics, Medical College of Georgia and chairman, Committee on Substance Abuse, American Academy of Pediatrics; (7) James Ryan, Dupage County State's Attorney, Wheaton, Illinois; (8) Brenda Smith, staff attorney, Director of Women in Prison Project, National Women's Law Center; (9) Pete Wilson, member, U.S. Senate, State of California; and (10) Robert Woodson, Sr., president, National Center for Neighborhood Enterprise. Relevant supplemental materials, prepared statements, and letters are included throughout the text. (NB)

FYI-CC

LAW AND POLICY AFFECTING ADDICTED WOMEN AND THEIR CHILDREN

ED325786

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, MAY 17, 1990

Printed for the use of the
Select Committee on Children, Youth, and Families

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LAW AND POLICY AFFECTING ADDICTED WOMEN AND THEIR CHILDREN

THURSDAY, MAY 17, 1990

House of Representatives,
Select Committee on Children,
Youth, and Families,
Washington, DC.

The committee met, pursuant to notice, at 9:37 a.m., in Room 1364, Longworth House Office Building, the Hon. George Miller (chairman) presiding.

Members present: Representatives Miller, Boggs, Weiss, Evans, Durbin, Packard, Hastert, Holloway, Smith of Texas, Smith of Vermont and Walsh.

Also present: Representatives Fawell and Hyde.

Staff present: Karabelle Pizzigati, staff director; Jill Kagan, deputy staff director; May Kennedy, professional staff; Dennis Smith, minority staff director; Carol Statuto, minority deputy staff director; and Joan Godley, committee clerk.

Chairman Miller. The select committee will come to order. In the last few months, the Select Committee on Children, Youth, and Families has devoted substantial efforts to examining substance abuse among pregnant and parenting women and to exploring prevention and treatment strategies. We have learned a great deal about the complex lives, motivations, and needs of women addicted to harmful substances. We have also been made aware of the shocking dearth of services that could help and support these women.

Providing outreach and treatment—not waiting lists—for pregnant, substance-abusing women is a great challenge for policymakers and for overwhelmed and underfunded service systems. But we have learned that we can meet this challenge. And we have learned that we cannot afford, nor should we tolerate, an increasingly popular alternative—the tendency to punish women and their children. Punitive actions do little to prevent or resolve the problems of addiction.

Out of our deep and abiding concern for children and families, we must provide more resources for education, treatment and the coordination of support services for addicted women. While we must attend to the needs of many drug-exposed children who will require special services, the recovery and self-sufficiency of their mothers are essential to ensure that children are served. Ridding the expecting mother of drugs is the best way to protect her baby from drugs.

Since 1986, when the select committee held its first inquiry into the effects of parental substance abuse on infants, Congress has failed to respond with sufficient resources or guidance to protect and serve women before, during and after pregnancy. We cannot excuse our inaction by arguing that we do not know what to do. More research is needed, but we already know enough to respond.

This spring, the select committee launched a series of hearings focusing specifically on the link between addicted mothers and the future of their children.

In the first hearing, we learned that women's addiction crosses all socioeconomic groups and dashes all stereotypes. We learned that treatment must be tailored to women's special needs, and that the path to recovery is predictably rocky. A brief relapse may not mean that treatment has failed.

The second hearing brought us to a model program for substance abusing women and their children in Detroit, the Eleonore Hutzel Recovery Center. Here we learned that there is evidence of success and hope for the future. We met with women receiving a wide range of inpatient and residential services, and saw that providing child care, a supportive and nurturing environment and responsive treatment could effect positive outcomes.

In testimony that followed our site visit, we heard new evidence that pregnancy may provide the strongest motivation and the best opportunity for successful drug treatment and intervention. Tragically, the handful of existing programs, such as Hutzel Hospital, can benefit only a small segment of a large and growing population of substance abusing women.

And even when success is demonstrated resoundingly, as it was in a smoking cessation program in a Michigan WIC clinic, providers often cannot continue their good work because of a lack of funds. We have heard that the current capacity of service systems nationwide is woefully inadequate to keep up with the skyrocketing demand for treatment. The population is estimated to be at least 4 times as large as the number of clients who can be treated in a year's time.

We can no longer ignore critical service needs of women such as child care and transportation. And we cannot condone the rising tide of criminalization of pregnant substance abusers and rest assured that we have dealt with this critical health and social problem.

I am pleased that the select committee is now at the point of examining Federal and state policies designed to address the urgency of perinatal substance abuse. Today we will hear from witnesses who will provide the latest information on state legislative legal remedies and will explain what we can do at the federal level to help out.

[Prepared statement of Hon. George Miller follows:]

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS, FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

HEARING: "LAW AND POLICY AFFECTING ADDICTED WOMEN AND THEIR CHILDREN"

MAY 17, 1990

In the last few months, the Select Committee on Children, Youth, and Families has devoted substantial efforts to examining substance abuse among pregnant and parenting women, and to exploring prevention and treatment strategies. We have learned a great deal about the complex lives, motivations, and needs of women addicted to harmful substances. We have also been made aware of the shocking dearth of services that could help and support these women.

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I am pleased that the Select Committee is now at the point of examining Federal and state policies designed to address the urgency of perinatal substance abuse. Today we will hear from witnesses who will provide the latest information on state legislative and legal activities, and will explain what we can do at the federal level right now.

A witness from California will release the results of a multiple-site survey of health and drug treatment providers demonstrating the need for more and better training among their respective professions.

Policy analysts and service providers will tell us how we can make recipients of Federal funds and private providers accountable for delivering services to women.

We will also hear how reimbursement and granting mechanisms can be changed so that drug treatment is adequately covered and professionals are better trained to respond to this complex problem.

We are especially pleased to welcome witnesses who will describe the drug treatment needs of Native American women and women in prison. The needs of these special populations of women, facing unique cultural and access barriers to community-based systems of care, must be taken into account in the development of any future policies.

Thank you all for coming. I look forward to your testimony.

WOMEN, ADDICTION, AND PERINATAL SUBSTANCE ABUSE

FACT SHEET

ILLICIT DRUG USE UP AMONG MILLIONS OF WOMEN ACROSS SOCIOECONOMIC GROUPS

- Over 5 million women of childbearing age (15-44) currently use an illicit drug, including almost 1 million who use cocaine and 3.8 million who use marijuana. (National Institute of Drug Abuse [NIDA], 1989)

- In a recent survey of 715 pregnant women in Pinellas County, Florida, nearly 15% tested positive for substance use, with no significant difference among socioeconomic groups. (National Association for Perinatal Addiction Research and Education [NAPARE], 1989)

- While actual drug use may not be significantly higher among pregnant minority women, they are ten times more likely than white women who use drugs to be reported to child abuse authorities. (NAPARE, 1989)

HEAVY SMOKING, ALCOHOL USE ON THE RISE AMONG YOUNG WOMEN

- Approximately 6 million American women are alcoholic or alcohol abusers. Despite stable drinking patterns among the general population over the past 25 years, recent studies indicate an increase among younger women who are heavy drinkers (5 drinks a day or more). (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1987; NIAAA, unpublished, 1990)

- Nearly 24% of American women smoke and the fastest growing group of smokers in this country are women under age 23. Every day, 2,000 young women start smoking. The percentage of women who smoke 25 or more cigarettes a day increased from 13% in 1965 to 23% in 1985. (Surgeon

General's Report [SGR], 1989; U.S. Department of Health and Human Services [DHHS], February 1990)

- Although pregnant women are just as likely as nonpregnant women to have ever smoked (43% to 45% respectively), pregnant women (21%) are less likely than nonpregnant women (30%) to be current smokers. Black women were the least likely of any group to smoke during pregnancy. (Williamson, 1989)

PREGNANT SUBSTANCE ABUSERS AT GREAT RISK OF AIDS, SEXUALLY TRANSMITTED DISEASES AND HOMELESSNESS

- In a survey of 337 pregnant substance abusers in 63 AIDS demonstration projects nationwide, 20% are homeless and 23% spent time in jail six months prior to the interview. (NIDA, unpublished data, 1990)

- Of the same 337 women, 36% engaged in sex for drugs or money, placing themselves and their babies at high risk for HIV infection; 98% engaged in vaginal sex, while only 4% used condoms consistently; and 15% had a sexually transmitted disease in the past 6 months. (NIDA, 1990)

- In New York City, pregnant cocaine abusers were 4.5 times more likely than nonusers to have a sexually transmitted disease. (New York City Department of Health [NYCDH], September 1989)

TREATMENT/PRENATAL CARE ELUSIVE FOR SUBSTANCE-ABUSING PREGNANT WOMEN AND MOTHERS

- At Boston City Hospital, 80% of mothers surveyed who used heroin or cocaine received no prenatal care. New York City cocaine abusers were 7 times less likely than non-abusers to have received prenatal care. (Amaro, 1989; NYCDH, 1989)

- Of 78 drug treatment programs surveyed in New York City, 54% exclude all pregnant women; 67% will not accept pregnant women on Medicaid; and 87% will not accept pregnant crack-addicted women on Medicaid. (Chavkin, 1989)

- Of California's 366 publicly-funded drug treatment programs, only 67 treat women and only 16 can accommodate her children. Similarly, Ohio has 16 women's recovery programs, and only two can accommodate her children. (Weissman, 1990; Ohio Department of Health, 1990)

- Reports show that 23% of women entering treatment, as compared to only 2% of men, encounter opposition from families and friends. Similarly, 48% of women experienced problems due to entering treatment, as compared to 20% of men. (Beckman and Amaro, 1984)

EFFECTIVE TREATMENT APPROACHES DOCUMENTED

- Pregnant women who participated in a smoking cessation program at a Michigan WIC clinic were 3.6 times more likely to quit smoking than nonparticipants. (Mayer, 1990)

- In a study of alcohol-using pregnant women in Atlanta, 35% discontinued alcohol use when presented information on the potential harm of alcohol use during pregnancy. (Smith, 1986)

- In Pinellas County, Florida, 77% of male and female substance abusers who are referred by the courts to Operation PAR, a comprehensive drug treatment program, and who complete the 18-to 24-month program do not reenter the criminal justice system. (Florida Department of Corrections, 1989)

- Of 54 babies born in 1989 to cocaine-using mothers enrolled at the Philadelphia Family Center, an outpatient drug treatment program for pregnant women and children, 75% were carried to full term. None were born prior to 33 weeks gestation. (Philadelphia Family Center, 1990)

INFANTS SERIOUSLY AFFECTED BY PERINATAL SUBSTANCE ABUSE

- A new eight-city survey reported that nearly 9,000 babies were born exposed to illicit drugs in 1989 at an estimated cost of $500 million for providing care through age 5. (Office of the Inspector General, 1990)

- Each year, Fetal Alcohol Syndrome (FAS) affects nearly 5,000 babies and is the third leading cause of birth defects associated with mental retardation. Thousands more children are born with Fetal Alcohol Effects (FAE), a milder form of FAS. (National Council on Alcoholism and Drug Dependency, 1988)

- Smoking increases premature deliveries, spontaneous abortions and still births. A pregnant smoker's infant is on average seven ounces lighter than babies of nonsmokers. (SGR, 1989)

- Between 1985 and 1988, the number of congenital syphilis cases increased by 130%. Experts estimate that there will be over 1,000 congenital syphilis cases in 1989. (Centers for Disease Control [CDC], 1990)

- As of February, 1990, there have been 2,116 reported cases of pediatric AIDS in children under age 13. Eighty percent of these pediatric AIDS cases are attributed to maternal transmission from an infected parent, and of these, 90% of the babies' mothers either use intravenous drugs or had heterosexual partners who were IV drug abusers. (CDC, 1990)

TREND TO PROSECUTE PREGNANT SUBSTANCE ABUSERS PROCEEDS

- To date, over thirty women have been criminally charged for drug use during pregnancy for delivery of drugs to a minor. A Florida woman has been convicted. Hundreds more pregnant substance abusers have been civilly charged for alleged child abuse. (American Civil Liberties Union [ACLU], February 1990)

Four states have amended definitions of child abuse to include drug use during pregnancy (Florida, Illinois, Oklahoma, Rhode Island) and 3 states have included alcohol and drug use during pregnancy (Indiana, Nevada, Utah); one state amended its definition of criminal child neglect to include prenatal exposure to controlled substances (Minnesota); and three states require doctors to report to the state if either the mother or the child has a positive urine toxicology screen (Minnesota, Oklahoma, Utah). (ACLU, February 1990)

4/19/90

With that, I'd like to recognize Mr. Packard.

Mr. Packard. Thank you, Mr. Chairman. I would ask unanimous consent that the ranking minority member have his statement entered in the record.

Chairman Miller. Without objection, so ordered.

[Prepared statement of Hon. Thomas J. Bliley, Jr., follows:]

PREPARED STATEMENT OF HON. THOMAS J. BLILEY, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA, AND RANKING REPUBLICAN MEMBER

Last October, Dr. John Niles, the President-elect of the Medical Society of the District of Columbia told this Select Committee that the infant mortality rate had declined to 18 percent in the District by 1983. In the following three years, the infant mortality rate increased slightly to 19 percent, 20 percent and 21 percent. And then, in a single year, the infant mortality rate skyrocketed to 30 percent in the District of Columbia. Dr. Niles testified that the only explanation for the explosion appeared to be the crack cocaine epidemic.

Last November, the Select Committee released a report on the increasing number of children who are being placed in substitute care. I believe that there is a consensus that substance abuse is the driving force behind those increases.

The first step in the public policy process is to identify a problem. Although others may choose to consider only some part of maternal addiction in isolation, any potential solution must be measured in terms of reducing the infant mortality rate and reducing the number of children in temporary, substitute placement. Unless the solutions we might consider deal squarely with these two problems, we will foil our own goal.

In light of the Select Committee's findings over the past year, and especially in light of the last two hearings, there is an obligation to forward at least the concepts of potential solutions. Three basic principles must guide us. First, there is no constitutional right to abuse drugs. We recognize the tension which exists in balancing the privacy rights of the mother with the fundamental right of survival of the child. But balance we must. We must recognize the rights of both child and mother, but in doing so, we must ensure that no person will be denied their interest in life, liberty, or property without due process. No one on this Committee or in this Congress is willing to undermine the Constitution even to rid ourselves of the cancer of drugs.

Second, there is a continuum of responses to drug abuse which will be employed based on appropriateness and reasonableness. The continuum of maternal and infant care begins with the identification of substance abuse. Physicans cannot treat what they have not diagnosed. We have heard that some pregnant women seek treatment on their own. We have also heard that drug use is substantially underreported. Reliance solely on self-identification will mean that many people needing treatment will not receive it. Testing is in the interest of both mother and child. It is recognized as an integral part of treatment, both at the beginning of therapy and along the way. If we are to place any credibility on our own findings, we must agree that there are cases in which testing at birth will be the only opportunity to protect the child from going home to a life-threatening situation and to begin treatment of mother and child. Early identification by testing of the newborn in the hospital gives the health professionals the opportunity to talk with the mother and begin the long road to rehabilitation before any more damage is done.

We are also concerned with the long-term developmental status of the child. For any child, the most important factor is a stable family life. According to the Associate Director of Pediatrics at St. Luke's—Roosevelt Hospital in New York, more than half of that hospital's boarder babies were placed in foster care. Only 21 percent remained with their mothers. Although we all owe our gratitude to the dedicated foster parents in this country, we all agree that foster care should be only temporary. It is in the child's interest that adoption proceedings are initiated as early as possible.

Finally, we know that more money will become available for treating maternal substance abuse and its affects on children. It is clear from the information we have gathered that substance abuse programs must be client-focused and community-based. Even after leaving residential treatment, a recovering addict will face many daily challenges in her own neighborhood. It is important that the federal government not stifle local efforts to provide services which draw their strength from churches, schools, and other partners in the community. The federal government must meet its obligations to provide the resources for treatment, but it would be a strategic mistake to smother the local programs with bureaucratic red tape. The decision-making regarding treatment should rest in the hands of the state and local authorities.

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LAW AND POLICY AFFECTING ADDICTED WOMEN AND THEIR CHILDREN

Minority Fact Sheet

May 17, 1990

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Prepared by:

Cathy Caridi, Cathy Deeds, and D. Jeffrey Hollingsworth

FINDINGS

Ethical Issues

Maternal substance abuse forces policymakers, physicians, and the legal profession into a number of potential conflicting positions. The balancing of rights generate ethical issues including: Is the mother criminally liable for any harm to the fetus or newborn? Should she be required to receive treatment for herself and the child? Should the child be taken into protective custody at birth?

Rights of the Child/Rights of the Mother

"All persons have obligations to refrain from harming children after birth. Similarly, they have obligations to refrain from harming children by prenatal actions. There is no reason why the mother who has chosen to go to term should not also have a duty to prevent harm when she may reasonably do so....Ethical analysis must balance the mother's interest in freedom and bodily integrity against the offspring's interest in being born healthy." [John A. Robertson, "Reconciling Offspring and Maternal Interests During Pregnancy," in Reproductive Laws for the 1990s, Sherrill Cohen and Nadine Taub, eds., Clifton, NJ: Humana Press, 1989, p. 259-260.]

"...women possess fundamental rights which preclude the kind and degree of government intervention...propose[d]. A pregnant woman has a right to refuse medical intervention and a right to be free of any unique criminal or civil liability for her conduct during pregnancy and birth." [Janet Gallagher, "Prenatal Invasions and Interventions: What's Wrong with Fetal Rights," Harvard Women's Law Journal, Vol. 10, p. 12.]

Balancing the State's Interest in Protecting Children and the Mother's Right to Privacy

"The belief that parents can best fulfill their responsibilities to their children if free from intervention is naive in the fetal abuse context. Children have separate and distinct legal rights, and are entitled to the protection of the law, even from their parents." [Sam S. Balisy, "Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus," Southern California Law Review, May 1987, p. 1231.]

"If the current trend in fetal rights continues, pregnant women would live in constant fear that any accident or "error" in judgment could be deemed "unacceptable" and become the basis for a criminal prosecution by the state or a civil suit by a disenchanted husband or relative." [Dawn E. Johnsen, "The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection," The Yale Law Journal, Jan. 1986, p. 605-607.]

Legal Intervention: Protecting the Infant or Punishing the Mother?

"...the conduct of the pregnant woman who takes heroin, knowing that she is pregnant and desirous of bearing a child, can be legally sanctioned in order to protect potential human life. There is no constitutional right implicated in the taking of heroin." (Jeffrey A. Parness, "Your Bodies, Ourselves: Legal Protection of Potential Human Life," The Catholic Lawyer, Vol. 30, No. 4, p. 373.)

"The state might pursue criminal prosecution for culpable prenatal conduct that causes severe impairment to offspring....this avenue is constitutionally within state authority. It may turn out to be an effective tool for demonstrating society's protection of children and deterring egregiously harmful prenatal conduct in certain cases." (John A. Robertson, "Reconciling Offspring and Maternal Interests During Pregnancy," in Reproductive Laws for the 1990s, Sherrill Cohen and Nadine Taub, eds., Clifton, NJ: Humana Press, 1989, p. 263.)

"Given that the proposals for forced treatment or physical restraint of pregnant women are more drastically intrusive into the familial relationship and immediately personal to the woman herself, there should be even greater judicial reluctance to override pregnant women's choices." (Janet Gallagher, "Prenatal Invasions and Interventions: What's Wrong with Fetal Rights," Harvard Women's Law Journal, Vol 562, p. 31.)

"One of the strongest objections to pressure or coercion is the risk of driving women out of the health care system, particularly women who may have the greatest need for medical attention because of drug abuse or other risk factors." (Norman Fost, "Maternal-Fetal Conflicts: Ethical and Legal Considerations," Annals of the New York Academy of Sciences, Vol. 562, 1989, p. 253.)

Testing Issues

The issue of testing newborns or expectant mothers for substance abuse is a controversial subject because of the conflict between a mother's right to privacy and the newborn's right to be born drug free. Although most hospitals routinely test newborns, for genetic disorders and other diseases without the mother's permission, the issue of testing for the presence of drugs is complicated by the uncertain position the mother faces. Should the hospital request the mother's permission before testing the newborn? Should the hospital rely on self-reporting by the mother even though that method is not very reliable?

Reasons for Testing: PRO

"Screening maternal and newborn urines for drugs has been recommended as part of the management of drug dependent mothers and infants for two reasons: 1) to establish or support a diagnosis of neonatal drug withdrawal and 2) to identify the drugs used in order to anticipate the course of withdrawal and to guide drug therapy if required. "

"Urine drug screening may assist neonatal or maternal management in several areas: 1) establishing a diagnosis of neonatal drug withdrawal, 2) monitoring the baby for specific drug-related clinical findings or delayed withdrawal signs, 3) selection of appropriate drug therapy for the baby, if required, 4) counseling the mother, and 5) preventing or treating maternal withdrawal. However, drug screening may not reliably predict neonatal withdrawal." [Enno C. Halstead, et al, "Timing of Specimen Collection is Crucial in Urine Screening of Drug Dependent Mothers and Newborns," Clinical Biochemistry, Vol. 21, January 1988, pp. 59-61.]

"Using screening questionnaires and urine tests to identify mothers at risk for chemical dependency and refer them for obstetric monitoring and chemical dependency treatment is an appropriate use of urine toxicology data." [Sidney H. Schnoll, MD, Ph.D, Lori Karan, MD, Medical College of Virginia Hospitals, Virginia Commonwealth University, Richmond. Letters, JAMA, Nov. 3, 1989, page 2384.]

"Drug screening tests are estimated to be between 98 and 100 percent accurate, while confirmation tests, such as a complex analytic technique called gas chromatography/mass spectrometry (GS/MS), are considered virtually 100 percent accurate when performed by knowledgeable lab personnel." ["Drug Testing for Illegal Substances," Congressional Research Service Brief (CRS), January 20, 1987, page 4-6.]

Reasons for Testing: CON

"In any discussion of drug testing methodology, it is critical to note that tests of this kind detect only the exposure or presence of an illegal substance in body fluids. The tests cannot be used to predict a tested subject's state of impairment or addiction. While possession of controlled substances is illegal, being under the influence of them is not."

"Generally speaking, groups opposed to the testing procedures make the claim that the tests are so inaccurate as to render them useless in an effort to curb the demand side of the drug use and abuse." ["Drug Testing for Illegal Substances," Congressional Research Service Brief (CRS), January 20, 1987, page 4-6.]

"Mandatory drug testing of all pregnant women is one other vehicle of punishment. For mandatory drug testing goes far beyond a simple urinalysis. It violates fundamental rights of privacy, the Fourth Amendment right against search and seizure, and the right to the equal protection of the laws." [Kary L. Moss, American Civil Liberties Union Foundation, New York. Letter to editor in JAMA, Nov. 3, 1989, p. 2384.]

Self-Reporting: Barrier to Treatment?

"Many drug-using mothers deny any drug use and do not give the doctor permission to test them and their babies for drugs. We tested 200 consecutive pregnant women anonymously for drugs. Thirty percent of them tested positive. During the same period the incidence of self-identified drug users was only 13%. This indicates that more than half of drug users denied drug use." [Prepared testimony of Jing Jo Yoon, MD, at "Beyond the Stereotypes: Women, Addiction, and Perinatal Substance Abuse," a hearing before the House Select Committee on Children, Youth, and Families, Washington, DC, April 19, 1990, p. 2.]

"The only study to assess systematically the validity of self-reporting of illicit drug use among a general population of adolescents showed that 33% of adolescents who denied smoking marijuana had a positive urine assay result for marijuana metabolites. No similar study of the validity of self-reporting of cocaine use among adolescents has been reported. In addition, no information is available regarding possible differences between adolescent girls and women." [Barry Zuckerman, MD, et al, "Validity of self-reporting of marijuana and cocaine use among pregnant adolescents" Clinical and Laboratory Observations, November 1989, p. 812.]

"The urine test results revealed even more women who smoked marijuana during pregnancy than those willing to admit to it in an interview. If marijuana use is underreported relative to alcohol and cigarettes as this study suggest, it is possible the potentially adverse effects of marijuana may be inadvertently misattributed to alcohol or nicotine." [Ralph Hingson, ScD, Barry Zuckerman, MD, et al, "Maternal Marijuana Use and Neonatal Outcome: Uncertainty Posed by Self-Reports", American Journal of Public Health, Vol. 76, June 1986, p. 667.]

"Self-reported drug use among pregnant women has been demonstrated to result in underidentification of illicit drug use compared with the combination of self-report and urine assay." [Hortensia Amaro, PhD, Barry Zuckerman, MD, et al, "Drug Use Among Adolescent Mothers: Profile of Risk," Pediatrics, Vol. 84, July 1989, p. 145.]

"Failure to identify cocaine users is extensive owing to the limitations of the two methods currently used to verify drug use. Maternal self-reported drug history, the first method, has been shown to be unreliable: many women who deny use during pregnancy exhibit cocaine metabolites in their urine. Urinalysis for cocaine, the second method, is hampered by the short elimination half-life of the drug and its metabolites: in adults, cocaine metabolites are often not detectable in urine 7 days after last use of the drug." (Authors report the detection of cocaine metabolites in maternal and neonatal hair as an accurate method of verifying gestational cocaine use.) [Karen Graham; Gideon Koren, MD, et al "Determination of Gestational Cocaine Exposure by Hair Analysis" Journal of the American Medical Association, Vol. 262, December 15, 1989, p. 3328.]

"Requiring informed consent is based on the common law and constitutional principles that an individual has a right to be free of nonconsensual bodily intrusions. For minors, parental or legal guardian consent must be obtained."

"Specific consent to drug testing may not be needed if the screen is medically necessary. Usually, a drug dependant newborn will exhibit signs of the drug dependence such as irritability, jitteriness, diarrhea, etc. A physician or hospital could argue that the toxicology screen is necessary to aid in diagnosis and treatment. If this is the case, the testing might be covered by the general consent for diagnosis and treatment form a prospective parent is asked to sign upon admission to the hospital." [Walter D. Connelly, Jr. and Alison G. Marshall, "Drug Addiction, AIDS and Childbirth: Legal Issues for the Medical and Social Services Communities," unpublished article, pp. 39-40.]

Mandatory Reporting Based on Testing

"Some states have elected to mandate reporting based on a different model, requiring reports of all cases in which the infants have tested positive for drugs. Illinois has amended the definition of "neglected child" in its child abuse reporting law to include any child "who is a newborn infant whose blood or urine contains any amount of a controlled substance...or metabolite thereof, with the exception of a controlled substance... whose presence in the newborn infant is the result of medical treatment administered to the mother or the newborn infant." [Public Act 86-275, Infants and Minors-Neglect-Controlled Substances, p. 1985 and Public Act 86-274, p. 1984 (Illinois 1989 Regular Session)]

"A system of mandatory child abuse reporting that is based on toxicology testing not only has the potential for driving pregnant women away from prenatal care, it also will impose significant burdens on their constitutional interests in privacy, autonomy, and family integrity....This system of intervention places major burdens on the constitutional rights of family privacy and integrity. Even when limited to a report and an investigation which determines that no further action is necessary, the intrusion's impact on the family can be significant." [Abigail English, "Prenatal Drug Exposure: Grounds for Mandatory Child Abuse Reports?", Youth Law News, Special Issue 1990, p. 7-8.]

Substance Abuse Treatment of the Female Offender

Of the 3,977 female inmates in the Federal prison system as of May 1990, 1,193 (30%) were identified as having a history of substance abuse. Of that number, 800 (67%) are voluntarily participating in substance abuse treatment. There are no Federal laws or regulations to obligate or coerce a prisoner to participate in treatment. [Federal Bureau of Prisons, Office of Drug Abuse Treatment, Washington, D.C., 5/14/90].

The Federal government spends more than $6 million annually on substance abuse treatment programs for both male and female inmates. The average cost per inmate for treatment is $8,000 a year, which is in addition to the average cost of $15,000 per year to maintain an inmate in the Federal prison system. (Ibid.)

"(T)he Federal Bureau of Prisons will devote $8 million to treatment services in Fiscal Year 1991. In addition, the Judiciary will dedicate $28 million for the Substance Abuse Treatment Program within the U.S. Probation Office to contract with treatment services for probationers and releasees required by court order to receive treatment...New and better enforced legal sanctions against parolees and probationers who test positive for drugs, together with new counseling and aftercare services, will also help convicted criminals remain drug-free." (The White House, Washington, D.C.: National Drug Control Strategy, January 1990, pp. 33-4)

The average adult female prisoner in the state corrections system is a high school drop-out and single parent, aged 25-29, who began using drugs and/or alcohol between ages 13 and 14 and, by the time of incarceration, was a daily drug abuser. Marijuana is the leading drug of abuse (used daily by 56%), followed by cocaine (used daily by 49%). (American Correctional Association (ACA), Laurel, MD: "What Does the Future Hold?", Summary of the ACA Task Force on the Female Offender surveys of local and state correctional facilities, May 1990, pp. 17-19.)

The average non-Federal female offender will have been arrested between two and nine times between the ages of 15 and 19 and will be serving a sentence of 5 years or less for either drug law violations or for a property crime (e.g., theft, robbery) committed to pay for drugs. Approximately 68% will have participated in a drug and/or alcohol treatment program before imprisonment. (Ibid., pp. 17-18.)

Both adult (33.4%) and juvenile (41.8%) female offenders cite psychological counseling as the service they most needed first upon incarceration. For both groups, this need is cited nearly twice as often as the need for drug abuse assistance (18.5% and 19.0%, respectively). (Research Advisory Services, Phoenix, AZ: "Tabulation of a Nationwide Survey of Female Inmates," May 1988, p. 34.)

Women in state prisons cite the need for vocational training (21.7%) and college-level education programs (11.7%) ahead of drug treatment (9.7%) when asked what programs they have heard of that they would most prefer to have offered in prison. Narcotics Anonymous was the top choice of 5.2%; Alcoholics Anonymous was selected by 1.7%. (Ibid, p. 35.)

Of the female inmates participating in drug or alcohol abuse treatment programs in local jails and state prisons, 94% of the adults and 78.8% of the juveniles state that they were helped by the alcohol program; 85.9% of the adults and 71.9% of the juveniles reported that they were helped by the drug program, even though participation in treatment is not cited as their primary need. [Ibid., p. [illegible]]

When asked, "During this incarceration, what program has helped you the most?", the chaplaincy/church program was cited equally with substance abuse programs (10.9%) by adult offenders. Education programs were cited most often (21.3%). Counseling, mental health therapy, and education programs were the leading answers among juveniles. Substance abuse programs was the fourth most cited answer (7.6%). [Ibid., p. [illegible]]

The Role of Medicaid

"Medicare and Medicaid eligible individuals requiring drug abuse treatment can receive all covered hospital and non-hospital services required to treat their condition. The Department (of Health and Human Services) estimates that $170 million will be spent by both programs on direct drug treatment costs (in FY 1990), consisting of $50 million for Medicare and $120 million for Medicaid. Of this, $110 million is for hospital-based expenditures...Non-hospital expenditures for Medicaid are approximately $60 million. It is not possible to estimate non-hospital Medicare expenditures at this time." [The White House, Washington, D.C.: National Drug Control Budget Summary, January 1990, pp. 128-29]

Medicaid will provide alcohol and drug abuse treatment as a mandatory inpatient and outpatient service at hospitals. Outpatient services are covered in a variety of ways and include clinic and rehabilitative services, counseling by credentialed personnel, and aftercare to prevent recidivism. States may use a mix of Federal and state funds to offer treatment via group homes or small settings of 16 beds or fewer. Thus, states are not precluded from providing Medicaid-covered non-institutional services that include outpatient rehabilitation and counseling. [Health Care Financing Administration, Bureau of Quality Assurance, program summary data, September 1989]

A Federally funded nine-state pilot study of Medicaid-financed substance abuse treatment services "indicate(s) that state Medicaid programs provide a variety of services to recipients with substance abuse problems...(A)lcoholism (treatment)...has been incorporated into mainstream Medicaid coverage and benefit policies in many states. As substance abuse becomes more clearly defined and as effective treatment modalities evolve, services tailored to this population will be more easily identified and developed." [Intergovernmental Health Policy Project, The George Washington University, Washington, D.C.: "Substance Abuse Treatment Services Under Medicaid: Results of a Nine-State Pilot Study," December 1989, p. 15]

Mr. PACKARD. Mr. Chairman, I appreciate your holding this series of hearings to investigate the problems of addicted women and their children. In earlier hearings, we have looked at treatment and prevention programs. Today we will discuss what policies and laws need to be in place in order to assure that those who need help receive it.

Babies born to addicted mothers are immediately put in a tough situation. Most are born with an addiction themselves, a truly painful experience for their new little bodies. They will face many other hardships because the person they depend on for care is not even able to care for herself in many instances.

I believe we must be able to offer help to these mothers, not only for their sake but for that of their babies. The first hurdle we face in reaching this goal is that of identification. In order to help addicted mothers, we must be able to identify them. Once it is determined that a woman does have a drug problem, we must see that she receives treatment. Only if she can overcome her addiction will she be able to give the care which her child deserves.

We must not burden our drug treatment programs with too many rules and regulations. Churches and other nonprofit groups can provide the support addicted women need. However, if there is too much red tape for them to cut through, they will have to spend their resources dealing with the bureaucracy and will not be able to offer effective treatment.

We're very fortunate, and I'm particularly pleased, to have Senator Pete Wilson from the State of California, my state, here to testify before us. He's become a leader in this issue and has introduced two important pieces of legislation on the Senate side, which would provide assistance in this area. I commend him for his efforts to address this growing concern and certainly wish to welcome him at this hearing and look forward to his testimony.

Thank you, Mr. Chairman.

Chairman MILLER. Mr. Fawell.

Mr. FAWELL. Thank you, Mr. Chairman. I appreciate the opportunity to address this Select Committee on Children, Youth, and Families today, although I'm not a member. The subject you are addressing, the tragedy of perinatal substance abuse is one which has long-interested me. The broad scope of your hearings have brought a new and important perspective to this growing problem.

I note, too, that a good friend of mine, Jim Ryan, State's Attorney of DuPage County, Illinois, and President of the Illinois State's Attorney Association, will also be testifying this morning. Mr. Ryan has had an abiding interest in this subject matter of today's hearing. I'm sure you'll enjoy his remarks.

I would like to take this opportunity to apprise the committee that I and the ranking member of the committee, Tom Bliley, and others who are joining us in what is truly a bipartisan bill, will today introduce what we refer to as the Abandoned Baby Adoption Act of 1990.

This bill amends the Social Security Act by directing states to amend their laws to provide that at birth abandoned babies and babies abandoned up to six months after birth are entitled to expedited adoption procedures. Conceptually, this bill states that a newborn baby is entitled to immediate bonding.

If parents abandon the child at birth or shortly thereafter, it is our belief that under these special circumstances the bonding needs of the child and his or her well-being are paramount.

The request for this bill came to me from a group of foster parents in Illinois who had witnessed too many instances where newborn babies, many addicted to drugs, got lost in what we would call "the system." They could have been adopted if some expedited procedures were available. Without such procedures in place, however, these babies were simply not adopted.

In other instances, such at-birth abandoned children were successfully placed into foster homes. Oftentimes, however, this family would be torn apart years later when a parent reappeared on the scene suddenly. Such a tragedy is recounted by Chicago Tribune's Bob Green in an article I think is or will be distributed to the committee members.

He writes of a little girl who had lived for all five years of her life with one set of foster parents, but was given back by "the system" to her biological mother, who appeared some four or five years after the at-birth abandonment. No thought or consideration was given by "the system" to the irretrievable bond of mutual love between the foster parents and the child.

I think you should read the story which Jo and Marge Procopio tell of their experience and what that child went through when she had to go to a halfway house. No cards, no contacts were made to this little girl during her first lonely Christmas. She had been five Christmases with the parents who, of course, were everything to her.

So our bill will hopefully prevent these tragedies, at least many of them, from recurring. I welcome your comments, Mr. Chairman, and members of this committee. I look forward to working with you on a concept which I believe should be agreeable to all.

I thank you again, Mr. Chairman, for giving me the opportunity to come before your committee and express my feelings.

Chairman MILLER. Congressman Weiss.

Mr. WEISS. Thank you, Mr. Chairman. I'm very pleased to join you in this very important hearing. You're addressing one of the great tragedies.

Chairman MILLER. Thank you. Our first witness will be Senator Pete Wilson. Pete, welcome to the committee. We look forward to your testimony and we appreciate your work in the Senate on behalf of these women and children. Proceed in the manner in which you're most comfortable.

STATEMENT OF HON. PETE WILSON, MEMBER, U.S. SENATE, STATE OF CALIFORNIA

Mr. WILSON. Thank you very much, Mr. Chairman. I am grateful to you and commend you for holding the hearings. I'm very grateful for your courtesy in extending me the opportunity to appear this morning at the head of a long list of witnesses.

Let me just say that your opening statement and the statement of the other members of the committee indicate your own keen awareness of the dimensions of the problem. It has become truly an epidemic.

I received a letter not too long ago from the young woman who was the Chief of Obstetrics and Gynecology at Harvard-UCLA Hospital in Los Angeles. She mentioned in clinical but, I thought, chilling precision her reasons for a statement that the incidents of addicted newborns is occurring at what she described as a logarithmic rate.

The document to point, she mentioned that in Los Angeles County in the year 1985 there had been something over 500 addicted newborns. In the following year there had been over 1000. In the year after, over 1500. In the following year over 2500. It was her projection that early in the 1990s, there would be 10,000 in Los Angeles County alone.

We have heard estimates commonly circulated that nationwide the number last year was 375,000. I have to think that is an underestimate, because this is not purely the problem of the inner cities. It is a problem that I find going up and down California. You go to Valley Medical Center in Fresno, in the heart of a great rural area, they are approaching an incidence of addicted newborns that is almost one in four.

Mr. Chairman, if we were not moved by compassion, we would be compelled to, as a matter of dollars and cents, deal with a problem that is not simply a problem; it is a tragedy, I think. Mr. Weiss did not overstate it in the least. Each of these cases is a terrible tragedy, but add to that the dimensions of it, the cost of it, and we're looking at an epidemic that threatens to bankrupt a health care system that is already strained beyond capacity.

I'd say that if there are any who remain that persist in the delusion that drug use is a victimless crime, they need only walk through or visit one of these neonatal intensive care units. Unfortunately, the opportunity is increasingly abundant. There are too many opportunities to do it.

These children lie writhing in cribs. They have to be swaddled to avoid doing themselves serious injury. The estimates as I say are that in our state the number will run to something like 72,000. That's an incredible burden on our health care system. It represents a doubling of the number of substance-abused births statewide since 1989. So this is truly exploding.

I listened with great interest to Congressman Fawell's remarks about the bill that he and Mr. Bliley are going to introduce, and I commend him. I commend the foster parents in his state whose wishes he is representing in introducing this legislation that will provide for expedited adoption. He has a right to be concerned about the bonding.

As we know full well, one of the most tragic and insidious aspects of crack use by a pregnant woman is that it seems to almost destroy the maternal instinct. There are all too many of these abandoned babies, euphemistically termed "boarder babies." The fact of the matter is, this phenomenon, this epidemic, as I think it is truly called, is one of human pain and suffering.

It is a story of hospitals under seige. It is a story of foster care systems that are strained beyond limit. That's why I was particularly interested in his remarks. It's a story of a swamped educational and social service system, struggling to try to meet what will be the special, educational and emotional and developmental needs. It's clearly a story about which we're not yet fully informed because we have not had sufficient experience yet to know full well what the special care needs of these children are going to be.

As I pointed out with my reference to the Valley Medical Center, it's not just a story of our inner cities; it is as well a story of rural communities. So, Mr. Chairman, you are not just to be commended, but I think that your statement is not an unfair condemnation of the Congress.

I suppose in fairness, we should point out that what has happened that has accelerated and magnified the dimensions of this problem is the happening of crack. It has become the drug of choice, the escape of choice. Tragically, it is within reach of virtually everyone, certainly the poorest of our society. It clearly has become the drug of preference for young women, or at least a sufficient number to produce these shocking statistics.

I don't think we need to dwell on the point, but if you think of it, the long-term implications for America are truly staggering in terms of who will be the earning members of society in a social security system and whether or not we can fulfill the concerns of many who wonder whether America can remain competitive in a global marketplace.

Those are real concerns but, candidly, I think that they are minor, as serious as they are, in comparison with the tragedy in the case of each of these children who, if subjected to prolong drug use during the pregnancy of the mother, will suffer permanent and serious injury, ranging from mental retardation to physical deformity to the heavy likelihood of the sort of neurological disorders that can mean real learning disability.

Let me, if I may, just direct the committee's attention to the chart in front of me. A moment ago I said if not compassion, at least our concern for tax dollars and the competition for those dollars should prompt the kind of concern which our committee clearly has.

This chart indicates the short- and long-term costs of caring for a single drug-exposed infant. What we did, Mr Chairman, was we asked state and local agencies in California primarily, but in a few other states, to estimate what they thought the costs would be for dealing with the problems of these children above and beyond that of so-called "normal children."

The medical costs which deal with the initial costs, that of neonatal and intensive care, represents on average $30,000. As you're well aware in the case of some of these boarder babies, those costs have escalated to a quarter of a million dollars.

The family costs, which relate to $11,000 a year for the child welfare agency investigation of child abuse and neglect, the kind of social services connected with foster care placement, averaging $13,000 a year; the special developmental costs to provide the kind of compensatory, developmental services that the State of California provides as well as an estimated $10,000 a year for special education services, total $134,000 per year, per child, well into and I'd say past adolescence.

I emphasize this does not relate to the long-term health care costs. They were unwilling to estimate those. So what we're talking about are state costs and local costs far in excess of what are being paid now. The most frightening aspect of that from a purely tax standpoint is that with the incredible increase, as Dr. Fonacura put it in her letter to me, an increase occurring at a logarithmic rate, we are seeing the tip of the iceberg.

So, what we are in need of doing, Mr. Chairman, as you have said, I think, with simple eloquence, we know what the problem is and we think we know what to do about it. What we have to do is reverse what has been a history of benign neglect on the part of the Congress but just plain neglect.

In 1989, fiscal year '89, Congress had appropriated a grand total of $4.5 million nationwide for demonstration projects at a time when, I think you are correct, we know what needs to be done. It is pretty difficult to be too severely condemnatory of young women who are using drugs during pregnancy, who then seek treatment only to find that treatment is not available.

So, what we have to do, obviously, is to provide outreach and education and make treatment available on a far broader scale than it is today. It is available primarily through the very good work of a number of private agencies working with some federal dollars chiefly through public agency referred clients.

But that is not even scratching the surface, even though we can all point to worthwhile projects and programs that we know are successful. You mentioned some in Michigan. You're doubtless familiar, nearer at hand, your own constituency with the success of Mandela House in Oakland. The problem with Mandela House is it has six residents.

A similar, slightly larger success story is now in operation as an arm of the WATTS Health Foundation in Los Angeles, UHURU House, appropriately taking its name from the Swahili word for freedom, because that is what it's providing its residents, freedom from the kind of addiction for themselves and their children that has really put them in bondage.

So, what we need to do is to provide greatly expanded treatment facilities We also are confronted with the reality that too many in our health care system really are not trained to identify the problem. That is to say, they are not trained to identify it even when given prenatal care.

There are some physicians who have become aware only belatedly that the patients whom they were looking at were in fact going through a pregnancy using drugs. In many instances, we have determined that the young women using drugs during their pregnancy were not aware of the impact of their drug use upon their children.

They were not aware of the trauma that they were visiting upon the fetus. We need to expend some money for the training of health care professionals and those within the child welfare system to see to it that they can identify and deal as early as possible in a preventive fashion.

Your remark, Mr. Chairman, is right on point. What we have to do is prevent. That means that we have to be prepared to lay out some big dollars for the kind of rehabilitation which, in the case of a drug-using pregnant woman, will, at the very least, prevent recurrence of this tragedy. Each member of this committee is familiar with some individual horror stories.

The Wall Street Journal, in a lead news story, approximately a year ago, recited the tragic history of a woman whom they identified only as Cheryl, whom I think had given birth to seven addicted newborns. My wife recently visited a clinic in California and found a woman there who had given birth to the ninth addicted newborn.

Those are not just isolated aberrations. In the Martin Luther King Center in Los Angeles, the average is two, but that's an average. That means that some of the women have given birth to three and to four. If we are to provide abandoned infants with the kind of caring and supportive home environment that Congressman Sabo is concerned about, our foster care system has got to possess the ability to increase the number of foster parents who are willing and, I might add, able to accept substance-abused infants because they are a very different challenge than a child who is not born addicted. There is need for the special training of foster parents that will allow them to deal with the exceptional requirements of these tragically exceptional children. I have introduced legislation, S-2505, the Substance Abuse During Pregnancy Act of 1990, which will provide additional federal support in these areas, from expanded education, outreach and treatment activities to the kind of additional resources for health care personnel, foster parents and child welfare workers. S-2505 seeks to create the kind of federal/state partnership that will seriously address maternal substance abuse.

Mr. Chairman, we've got to ask, what about the substance abuse in women who may want very desperately to end their addiction, who may want to do no harm and to provide the absolute best environment for their children but who simply lack the ability, being in the thrall of some fiercely addicted drug, typically crack, so that they are unable to voluntarily seek treatment and end drug abuse during pregnancy.

How do we ensure that these women will not continue the recurrence and give birth not to one but to two, three and four more substance-abused infants? Well, I would submit that here we need to confront a problem which you mentioned in your opening statement.

Our purpose should not be punitive. It must be preventive. The question is, how do we best deal with a woman who is unable to come forward voluntarily, but the woman who we find to be using during pregnancy, the woman who has delivered an addicted child? How do we see to it that she does not continue her habit, injuring her own health and posing an incredible threat to her own children, not only the one that she has had but the next one or two that she may have?

It is not a cruelty to subject a woman to rehabilitation. I think that it is not only infinitely fair to her but clearly it is required if we are to avoid this tragedy of recurring drug-addicted newborns. For those that cannot kick that habit by themselves—and I recently have sat with young women in UHURU House. I asked them, do you think that you would be able to escape your continued addiction if you were not in this residential setting?

They indicated that they thought they would have no hope of doing so; that they depended upon the around-the-clock reinforcement, the support that they were getting in this residential environment that they would get nowhere else. I've been to one or two of these residential homes in which most of the people present had come voluntarily or with a slight nudge.

What I think we need to confront is the fact that we cannot depend upon voluntary attendance. We've got to do something about the women who are unable to help themselves and their children. I have had a number of conversations with the founder of Phoenix House, someone I'm sure known to you, Dr. Mitch Rosenthal.

When I was at first concerned with how we deal with the problem, I asked him, I said, the contention is made, Dr. Rosenthal, that only those who come voluntarily to treatment will succeed in rehabilitation. He said, that is flat nonsense. He said, do not let anyone tell you that.

People who have been brought to it kicking and screaming who were involuntary to understate the case have emerged from this kind of treatment, in fact, a very good risk to stay clean. It takes 14 to 18 months, whether you're talking about Phoenix House or whether you're talking about Mandela House, UHURU House. These are not quick fixes because you're talking about fierce addiction; in the case of some of these women, years long addictions where they've gone from one substance to another.

Mr. Chairman, let me just say that I think that any congressional effort that seeks to deal with the kind of problem that is being confronted daily and in our rhythmic, increasing progression in the cities, large and small, urban and rural, of America is one that has to confront not only the need for tremendously expanded treatment, as is proposed under 2505, but it also needs to deal with how we get women who are not capable of coming voluntarily to that treatment.

There will be some who say that any involuntary commitment is punitive. I simply reject that. I do not think it punitive to cure someone and to prevent the kind of tragedy that otherwise is almost bound to recur. There can be a legitimate discussion as to whether or not the procedure needs to be one that is a hybrid variation on the criminal system that simply seeks not to incarcerate but to require the kind of treatment that we are familiar with in Phoenix House, Mandela House, UHURU House.

If it can be done by civil commitment, all the better, but in many states, there is not a procedure for civil commitment. What I think can be done in that case is the enactment of legislation at the state level which, if it can't and doesn't create a sufficient civil commitment system, it could be an adaptation on a system.

Many states presently require the reporting by physicians and child welfare personnel of child abuse. This is child abuse of the most serious kind, through the umbilical cord. It may be totally involuntary in terms of the intended consequence. It is nonetheless damaging. What we need to do is to encourage the states to take the kind of steps that will respond to both those strong enough to come voluntarily and those who are not.

I submit that we need to deal with this in this session because we have no time to waste. I remind all who don't know, as this committee does, that Dr. Fonacura is not exaggerating. I think when she calls it a logarithmic progression, she's right.

Mr. Chairman, thank you again for your diligence. Thank you for the courtesy of listening to me this morning.

[Prepared statement of Hon. Pete Wilson follows:]

Statement of Hon. Pete Wilson, a U.S. Senator From the State of California

THANK YOU, MR. CHAIRMAN, FOR THE OPPORTUNITY TO APPEAR BEFORE YOU THIS MORNING.

AS THE COMMITTEE HAS LEARNED DURING PREVIOUS HEARINGS, MATERNAL SUBSTANCE ABUSE DURING PREGNANCY HAS HAD A CHILLING EFFECT UPON THE NATION.

IF THERE REMAIN ANY WHO PERSIST IN THE DELUSION THAT USE OF ILLEGAL DRUGS IS A VICTIMLESS CRIME, LET THEM WALK THROUGH A NEO-NATAL INTENSIVE CARE WARD FULL OF BABIES INNOCENTLY ADDICTED TO DRUGS OR ALCOHOL.

THEY WRITHE IN THEIR CRIBS IN MATERNITY WARDS ACROSS THE NATION, EMITTING HIGH PITCHED CRIES OF PAIN. EVEN THE MOST EXPERIENCED, MOST CARING NURSES CANNOT NOT CALM THEM.

ACCORDING TO THE NATIONAL ASSOCIATION OF PERINATAL ADDICTION, RESEARCH, AND EDUCATION, 375,000 SUBSTANCE ABUSED INFANTS ARE BORN EACH YEAR.

IN OUR STATE ALONE, MR. CHAIRMAN, LATEST ESTIMATES INDICATE THAT 72,000 INFANTS WILL BE BORN SUBSTANCE ABUSED THIS YEAR. THIS FIGURE REPRESENTS A DOUBLING OF THE NUMBER OF SUBSTANCE ABUSED BIRTHS REPORTED STATEWIDE IN 1989.

THE TRAGIC STORY OF THESE INFANTS IS ONE OF HUMAN PAIN AND SUFFERING. CONSIDER JAMES WHO ROCKS HIMSELF TO SLEEP AT NIGHT BY STICKING HIS FINGERS IN AN ELECTRICAL SOCKET.

IT'S A STORY OF HOSPITALS UNDER SIEGE. FROM SAN DIEGO TO REDDING, HOSPITALS REPORT ALARMING BIRTH RATES FOR SUBSTANCE ABUSED INFANTS.

IT'S A STORY OF FOSTER CARE SYSTEMS STRAINED BEYOND LIMIT. MANY SUBSTANCE ABUSED INFANTS ABANDONED BY OR TAKEN AWAY FROM THEIR MOTHERS REMAIN IN STATE CUSTODY FOR LACK OF WILLING FOSTER FAMILIES.

IT'S A STORY OF SWAMPED EDUCATIONAL AND SOCIAL SERVICE SYSTEMS STRUGGLING TO MEET EDUCATIONAL, EMOTIONAL, AND DEVELOPMENTAL NEEDS. LOS ANGELES UNIFIED SCHOOL DISTRICT, INUNDATED WITH CHILDREN IMPAIRED BY MATERNAL SUBSTANCE ABUSE DURING PREGNANCY, HAS DEVELOPED A SPECIAL EDUCATION CURRICULUM FOR SUBSTANCE ABUSED CHILDREN.

IT'S A STORY OF OUR INNER CITIES. IN LOS ANGELES COUNTY, OVER 10,000 SUBSTANCE ABUSED INFANTS ARE EXPECTED IN MATERNITY WARDS BY 1993.

IT'S A STORY OF OUR RURAL COMMUNITIES. DEEP IN THE AGRICULTURAL HEART OF CALIFORNIA, A FRESNO COUNTY HEALTH FACILITY REPORTS THAT TWENTY PERCENT OF ALL BIRTHS INVOLVE A SUBSTANCE ABUSED INFANT.

MR. CHAIRMAN, CARING FOR THESE INFANTS WILL REQUIRE A SUBSTANTIAL INVESTMENT OF OUR TIME, ENERGY, AND RESOURCES.

IF I COULD DIRECT THE COMMITTEE'S ATTENTION TO THE CHART IN FRONT OF ME, I WOULD LIKE TO OUTLINE THE COSTS ASSOCIATED WITH THE CARE OF JUST ONE SUBSTANCE ABUSED INFANT.

EACH SUBSTANCE ABUSED INFANT WILL REQUIRE ROUGHLY $134,000 ANNUALLY IN SOCIAL, EDUCATIONAL, AND DEVELOPMENTAL SERVICES. FOR THE MOST SEVERELY IMPAIRED, THE NUMBERS ON THE CHART REFLECT LIFETIME NEEDS.

STATE COSTS INCLUDE $30,000 FOR INITIAL HEALTH CARE AND DELIVERY OF THE INFANT, $11,000 PER YEAR FOR CHILD WELFARE AGENCY INVESTIGATIONS OF CHILD ABUSE AND NEGLECT, $13,000 PER YEAR FOR FOSTER CARE PLACEMENT, $10,000 PER YEAR FOR SPECIAL EDUCATION SERVICES, AND $70,000 PER YEAR FOR STATE DEVELOPMENT SERVICES.

I SHOULD EMPHASIZE THAT THE $134,000 FIGURE DOES NOT TAKE INTO ACCOUNT LONG-TERM FISCAL IMPLICATIONS FOR REQUIRED HEALTH CARE, NOR DOES IT ADDRESS HUMAN PAIN AND SUFFERING CAUSED BY SUBSTANCE ABUSE DURING PREGNANCY.

HOW DO WE ESTIMATE THE COST OF DIMINISHED PHYSICAL AND MENTAL CAPACITY OR A LIFETIME OF BROKEN DREAMS AND HEARTBREAK?

MR. CHAIRMAN, IT IS A TRAGEDY IMPOSSIBLE TO MEASURE FULLY, BUT THANK GOD, IT IS PREVENTABLE.

BUT IF WE PROVIDE WIDELY AVAILABLE, QUALITY PREVENTIVE OUTREACH AND TREATMENT, WE CAN EMPOWER MOTHERS CAPABLE OF TURNING AWAY FROM SUBSTANCE ABUSE TO DO SO EARLY IN THEIR PREGNANCY TO PREVENT GREAT INJURY TO THEIR BABIES.

THAT MEANS INCREASED EXPENDITURES FOR DRUG TREATMENT.

IF OUR NATION'S HEALTH CARE SYSTEM DETECTS MATERNAL SUBSTANCE ABUSE EARLY IN A PREGNANCY, WE CAN ENCOURAGE PREGNANT ADDICTS TO ENTER TREATMENT.

THAT MEANS INCREASED EXPENDITURES FOR THE TRAINING OF MEDICAL AND HEALTH CARE STUDENTS, AS WELL AS ADDITIONAL EDUCATION FOR THOSE WHO CURRENTLY ARE PRACTICING.

IF WE ARE TO MINIMIZE THE SUFFERING EXPERIENCED BY SUBSTANCE ABUSED INFANTS WHOSE MOTHERS CONTINUE TO USE, OUR NATION'S CHILD WELFARE SYSTEM MUST BE CAPABLE OF DETECTING AND ADDRESSING MATERNAL SUBSTANCE ABUSE.

THAT MEANS INCREASED EXPENDITURES FOR PERSONNEL TRAINING AND THE ESTABLISHMENT OF PROTOCOL FOR IDENTIFYING, TRACKING, AND MONITORING SUBSTANCE ABUSED INFANTS AND THEIR FAMILIES.

IF WE ARE TO PROVIDE ABANDONED INFANTS WITH A CARING AND SUPPORTIVE HOME ENVIRONMENT, OUR NATION'S FOSTER CARE SYSTEM MUST POSSESS THE ABILITY TO INCREASE THE NUMBER OF FOSTER PARENTS WILLING TO ACCEPT SUBSTANCE ABUSED INFANT PLACEMENTS.

THAT MEANS ADDITIONAL EXPENDITURES FOR THE TRAINING AND RECRUITMENT OF FOSTER FAMILIES.

I HAVE INTRODUCED LEGISLATION, S. 2503, THE SUBSTANCE ABUSE DURING PREGNANCY ACT OF 1990, TO PROVIDE ADDITIONAL FEDERAL SUPPORT IN THESE AREAS.

FROM EXPANDED EDUCATION, OUTREACH, AND TREATMENT ACTIVITIES TO ADDITIONAL RESOURCES FOR HEALTH CARE PERSONNEL, FOSTER PARENTS, AND CHILD WELFARE WORKERS, MY BILL CREATES A FEDERAL-STATE PARTNERSHIP TO ADDRESS MATERNAL SUBSTANCE ABUSE.

BUT, MR. CHAIRMAN, WHAT ABOUT THOSE SUBSTANCE ABUSING WOMEN WHO BECAUSE OF THE FIERCELY ADDICTIVE AND DESTRUCTIVE NATURE OF CRACK ARE RENDERED UNABLE TO STEP FORWARD FOR TREATMENT AND WHO GIVE BIRTH TO A SUBSTANCE ABUSED INFANT?

HOW DO WE ENSURE THAT THESE WOMEN WILL NOT GIVE BIRTH TO TWO, THREE, OR FOUR MORE SUBSTANCE ABUSED INFANTS?

I SUBMIT THAT WE INSIST THESE WOMEN ENTER THE KIND OF CARING, COMPREHENSIVE TREATMENT NECESSARY TO BREAK THE CYCLE OF ADDICTION.

SIMPLY, WE MUST ASK OURSELVES: IS IT PUNISHMENT TO INSIST THAT FEMALE ADDICTS WHO HAVE GIVEN BIRTH TO TREATMENT NEEDED TO LEAD A DRUG-FREE LIFE AND GIVE BIRTH TO HEALTHY BABIES?

IS IT CRUEL TO SUBJECT WOMEN TO A CARING AND SUPPORTIVE LIVING ENVIRONMENT WHERE SHE CAN LEARN TO RESIST THE TEMPTATION OF DRUGS?

WHAT ABOUT THE PUNISHMENT INFLICTED BY PREGNANT ADDICTS UPON A GENERATION OF INNOCENT AMERICAN CHILDREN?

FOR THOSE PREGNANT ADDICTS WHO ARE UNABLE TO KICK THEIR HABIT VOLUNTARILY, WE SHOULD REQUIRE THAT THEY ENTER COMPREHENSIVE TREATMENT PROGRAMS UPON GIVING BIRTH TO A SUBSTANCE ABUSED INFANT.

MANDATORY TREATMENT IS A PREVENTIVE AND REHABILITATIVE APPROACH ESSENTIAL TO THEIR OWN HEALTH, TO THAT OF THEIR INFANT, AND TO THE HEALTH OF FUTURE CHILDREN.

SOME HAVE LABELED THIS APPROACH AS PURELY A PUNITIVE EXERCISE. IT IS NOT. IT IS A PREVENTIVE ACTION WHICH OFFERS US THE BEST HOPE TO END THE TRAGEDY OF MATERNAL DRUG ABUSE DURING PREGNANCY. JUST SPEAK TO THE ADDICT.

I RECENTLY VISITED THE HOUSE OF UHURU, OPERATED BY THE WATTS HEALTH FOUNDATION OF LOS ANGELES, CALIFORNIA, AND I ASKED THE WOMEN IN TREATMENT IF THEY COULD GET OFF CRACK WITHOUT RESIDENTIAL CARE AND MORE IMPORTANTLY, COULD THEY COME CLEAN VOLUNTARILY?

THEIR RESPONSE WAS "NO."

MR. CHAIRMAN, TREATMENT MUST BE THE RULE NOT THE EXCEPTION.

ANY POLICY RESPONSE FAILING TO INSIST ADDICTS WHO HAVE GIVEN BIRTH TO A SUBSTANCE ABUSED INFANT ENTER TREATMENT REPRESENTS A FAILURE ON OUR PART. MUCH WORSE, IT SAYS WE CONDONE CONDEMNING GENERATIONS OF INNOCENT AMERICAN CHILDREN TO LIVE LITERALLY THE LIFE OF THE DAMNED.

I HAVE INTRODUCED S. 1444, LEGISLATION WHICH WILL SEE TO IT THAT SUBSTANCE ABUSING PREGNANT WOMEN GET THE TREATMENT THEY NEED. IT OFFERS A COMPASSIONATE RESPONSE TO A TRAGIC PROBLEM WHICH AFFECTS US ALL.

S. 1444 WOULD AUTHORIZE $50 MILLION FOR FIVE STATE TREATMENT DEMONSTRATION PROJECTS.

BRIEFLY, MR. CHAIRMAN, TWO IMPORTANT GOALS MUST BE MET BY GRANT APPLICANTS UNDER MY LEGISLATION.

AGGRESSIVE PREVENTIVE OUTREACH AND EDUCATION EFFORTS MUST BE PURSUED TO IDENTIFY PREGNANT SUBSTANCE ABUSING WOMEN IN THE HOPE OF MINIMIZING LONG TERM EFFECTS UPON THE CHILD. ONCE IDENTIFIED, THESE WOMEN MUST BE AFFORDED THE OPPORTUNITY TO VOLUNTARILY RID THEMSELVES OF THEIR ADDICTIONS.

BUT FOR THOSE WOMEN WHO GIVE BIRTH TO SUBSTANCE EXPOSED INFANTS, THE STATE MUST INSIST THEY ENTER COMPREHENSIVE DRUG REHABILITATION.

I HOPE THE COMMITTEE WILL GIVE SERIOUS CONSIDERATION TO BOTH S. 1444 AND S. 2505. THEY REPRESENT TWO IMPORTANT STEPS TOWARD ENDING THE TRAGEDY OF SUBSTANCE ABUSE DURING PREGNANCY.

MR. CHAIRMAN, THANK YOU FOR INDULGING ME THIS MORNING. I LOOK FORWARD TO WORKING YOU ON THIS URGENT NATIONAL PRIORITY.

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Chairman MILLER. Well, thank you very much for your testimony. As I say, your interest and your willingness to legislate resources for this problem, I think, is—we have just finished watching this Senate struggle with trying to get resources to communities that have been overwhelmed and had their resources devastated by AIDS. We, too, are going to have to address communities that are absolutely overwhelmed by addicted women and children.

At some point we've got to look down the road in terms of what do you do with people who won't take treatment and continue in the destructive path. At the moment, it seems to me that some of that debate is unnecessary because the real question is whether we're even willing to help the people who are walking in on a daily basis, as we see in almost every part of the drug problem.

We have hundreds of thousands of people a year who call and ask for help and they get put on hold—they get put on a waiting list. We've heard this in our field hearings, time and again--in the City of Detroit we have 22 beds. They have more than all the women they can handle who are willing to occupy those residential placements.

The City of Seattle last week, we're talking maybe again a handful of residential placements with the recognition that if you're really going to help these women, you need an all encompassing program. The fact that this is going to be 30 days slap dash and you're out on the street again. There is not a lot of evidence that we're using those resources wisely.

But that's just a little bit of emphasis. I think your recognition of the problem, your willingness to do something about it is appreciated because I think, as you pointed out, we're learning more and more and what we'll learn today is that these are the most expensive babies born in American history.

At some point, we've got to come to grips with that. They have essentially, the best we can tell to date, overwhelmed every institution that they've come up against, starting at the time before birth and all the way into the school systems now. There is simply no system that has sufficient resources to deal with these babies on the basis on which they should.

Tragically, we're not putting the resources into preventing the birth of these babies that we should. Thank you for taking your time. Thank you very, very much.

Mr. WILSON. Mr. Chairman, thank you.

Chairman MILLER. Get that bill out and send it over here; will you?

Mr. WILSON. What's that?

Chairman MILLER. Get the bill out of the Senate and send it over here.

Mr. WILSON. Let me just make one final point to you because there are decent people who don't understand the dimensions of the problem. People have said to me when I've spoken of the kind of rehabilitation that takes 14 to 18 months, they said, my God, isn't that terribly expensive?

The answer is, it's not cheap, but it's a whole lot less expensive than continuing to deal with this epidemic of drug addicted newborns. If they are interested in a cost comparison, I'd say as a rough rule of thumb, you can probably put four women through Mandela House for the cost of one addicted newborn.

So I think that this is an instance where whatever your ideology, if you think that we need to be both compassionate and prudent in terms of resources, this is the time to engage in some preventive spending to avoid a far, far greater burden in infinite ways down the road, because the remedial, the reactive step will be infinitely more expensive, far less cost effective, far less humane. So, thank you, sir.

Chairman MILLER. Thank you for your time. The next panel that the committee will hear from will be made up of Susan Galbraith, who is the Director of Coalition on Alcohol and Drug Dependent Women and Their Children in Washington, D.C.; Brenda Smith, who is a Staff Attorney and the Director of Women in Prison Project, Washington, D.C.; Dr. Neal Halfon, who is the Director for the Center for the Vulnerable Child, Children's Hospital in Oakland California; David Gates, Staff Attorney for the National Health Law Program; and Robert Woodson, Sr., who is President of the National Center for Neighborhood Enterprise, Washington, D.C.

Welcome to the committee. I appreciate you taking your time to help the committee on this subject. Your written statements and whatever supporting documents you think are necessary will be placed in the record.

Susan, we'll begin with you. You may proceed in the manner in which you're most comfortable.

STATEMENT OF SUSAN GALBRAITH, DIRECTOR, COALITION ON ALCOHOL AND DRUG DEPENDENT WOMEN AND THEIR CHILDREN, WASHINGTON, DC

Ms. GALBRAITH. Thanks. Mr. Chairman, thank you for the invitation to be here today. I'd just like to begin by thanking you for your very thoughtful and compassionate leadership on this issue. It's something that we desperately need and something that we really will continue to support you in your efforts with.

My name is Susan Galbraith. I am the Director of the Coalition on Alcohol and Drug Dependent Women and Their Children. I am a former Associate Director for Public Policy for the National Council on Alcoholism and Drug Dependency. I'm a former treatment provider for alcohol and drug dependent women and their children.

I come to you today from the perspective of somebody who has worked for the last 15 years in trying to improve services for women and their children in this country. I'd like to really make two points today. I'd like to talk about the coalition, why it began, what our work is. Then, I've been asked specifically to talk about what we can do to improve federal efforts to serve women and their children.

This coalition was started a year ago this month in an effort to bring together the alcohol and drug field, the child welfare field, the maternal and child health field, legal services and women's organizations in response to the growing crisis in care for alcohol and drug dependent women and their children.

Our focus and our reason to begin our efforts was in direct response to the movement across the country to criminalize alcohol and drug use during pregnancy. We believe that this is a public health issue and that it is most appropriately dealt with through the public health system, not through the criminal justice system.

The coalition has made major progress in developing policies in the area of federal proposals for improving services, state proposals for improving services. We're currently involved in conducting a major survey looking at what services are out there for women and their children. We're doing major public education campaigns.

I have submitted to your staff a list of our federal proposals. I'd be happy to provide them for other members of the committee.

I'd like to speak very directly about one proposal today and that is the women set aside of the alcohol drug abuse and mental health services block grant. That requirement was enacted in 1984 to enhance services for women. Our experience in this country has been that unless the federal government mandates that states develop services for alcohol and drug dependent women, they do not happen.

It's like trying to get a splinter out of a two-year-old's toe. It's an impossible, very painful task to get states to seriously acknowledge that women have alcohol and drug problems, that they need specialized treatment, that if you set up services that are sensitive to their needs, that they will come in.

Tragically, we have seen that even with the federal mandate, to set up services for women, states have still gone around that mandate and they have not followed through in that requirement. Since 1985, a total of $364 million has been required to be spent on services for women in the states. I'm here to tell you that that certainly has not happened or we wouldn't be seeing this crisis in care that we're seeing today.

I would really urge you to look at your own State of California where a centralized categorical grant process was required in implementing the set aside, where that money was not distributed through the county system where it was easily used to support other services, but where a system was put in place to assure that separate, discrete, sensitive services for women were established.

We saw in California that that was done on the alcohol side. It was not done on the drug side. We saw in California that over 20 new programs were set up on the alcohol side for women. We do not see that same evidence on the drug side. We don't know what actually was done with that money. I would really urge you to look at what we already have in place and how that can be enhanced to make sure that services get out there for women.

Just finally, I'd like to comment on much of this discussion about mandating women to get into treatment. We have no treatment to mandate women to get into in the first place. I think this is a discussion that we may have the luxury of having two decades from now. If we were to take the women that were going to D.C. General today for prenatal care and delivery who are alcohol and drug dependent and try to find voluntary treatment for them, we would be hard-pressed to place them.

We have not been successful in setting up services for alcohol and drug dependent women. When we have set up services, what we have found is that women do come in for treatment. They are very interested in getting sober and drug free. They are very interested in getting well and that services do work.

Just finally, I'd like to go back to my opening point and really urge you—we are in a period of time where a war on drugs in many cases is becoming a war on drug users. It's becoming an effort that is really alienating and isolating already very alienated and isolated individuals.

We need to maintain our gains of the last decade and continue to press forward in our acknowledgment of these public health issues that are highly treatable and that women and men every day do recover. So, I'd like to close. Thank you very much for your time and for the opportunity to be here.

[Prepared statement of Susan Galbraith follows:]

PREPARED STATEMENT OF SUSAN GALBRAITH, DIRECTOR, COALITION ON ALCOHOL AND DRUG DEPENDENT WOMEN AND THEIR CHILDREN, WASHINGTON, DC

Mr. Chairman and members of the Committee, it is an honor to be here to testify before you today on the need to enhance services for alcoholic and drug dependent women who are pregnant and of child-bearing age and their children. My name is Susan Galbraith. I am the Director of the Coalition on Alcohol and Drug Dependent Women and Their Children. I have worked as an advocate for alcoholic and drug dependent individuals and their families as the Associate Director of Public Policy for the National Council on Alcoholism and Drug Dependence. I have worked as a program director and as a counselor in both residential and outpatient programs serving alcoholic and drug dependent women and their children.

The Coalition on Alcohol and Drug Dependent Women and Their Children was organized by the National Council on Alcoholism and Drug Dependence (NCADD)* in May 1989 in response to our concern about the growing trend across the nation to punish rather than intervene and provide treatment for women who are alcoholic and drug dependent and pregnant.

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* NCADD was established in 1944 to stimulate public education and public advocacy efforts on behalf of individuals with alcoholism and their families. The NCADD mission was expanded in 1988 to include individuals with other drug dependencies and their families. NCADD has led efforts nationally to enhance services for alcoholic and drug dependent women and their children.

There have been numerous prosecutions in many states across the nation. Women are being tried for charges ranging from child abuse, to delivery of drugs to a minor, to manslaughter. In virtually all cases, the women being tried are low-income and/or women of color. They are women who have limited resources and no access to good health care.

The National Council on Alcoholism and Drug Dependence (NCADD) established the Coalition in an effort to refocus the discussion on the need for prevention and treatment services for women and their children. NCADD unequivocally opposes the criminal prosecution of women who are alcoholic and drug dependent on the basis of their alcohol and drug use during pregnancy. It is this very basic tenet that guides NCADD's philosophical and financial commitment to the Coalition. These are public health problems that respond well to public health interventions. NCADD invited organizations and individuals concerned about women's health care, legal issues, civil rights, child welfare, alcohol and drug problems, mental health, and maternal and child health to join together to meet and organize appropriate interventions to address the current crisis in care for addicted women and their children (Coalition Statement of Purpose attached).

The Coalition currently has 38 organizational members. There are also concerned citizens who are individual members. The range of groups includes many of the major national organizations concerned with the health and well-being of women and their children (a list of Coalition members is attached). There are an additional 30 groups who participate in the Coalition who are not formal members.

The Coalition carries out its work through an Executive Committee and three standing committees: Legal Issues and Public Policy; Treatment and Services; and Prevention and Education.

The Public Policy and Legal Issues Committee has drafted proposals for legislative responses to address the needs of alcoholic and drug dependent women, their infants, and children for federal and state policy makers. The federal packet addresses a wide range of programs reflecting the Coalition's firm belief that these problems are systemic and that interventions must address the conditions of women's lives including poverty, unemployment, and lack of access to health care. The state packet provides model legislative proposals for enhancing state and locally based services for women and their children.

The Treatment Committee has conducted a survey of programs which provide prevention and treatment services for alcoholic and drug dependent women and their children. There is currently no reliable directory which provides information on the availability of services for women in the nation nor is there accurate information on the numbers of programs, numbers of women being served, or success of the interventions. This survey is an initial effort to begin to collect data.

The Prevention and Education Committee has compiled a comprehensive education packet for over 2,500 caregivers on alcohol and drug related birth defects. The packet is used in conjunction with National Alcohol and Other Drug Related Birth Defects Awareness Week which started this week on Mother's Day. This is an annual event which has been sponsored by NCADD and the Office for Substance Abuse Prevention to raise awareness about the risks of using alcohol and drugs during pregnancy and to encourage the implementation of prevention activities.

The Coalition has grown in size and strength over the past year. We have made tremendous progress in opening up discussions between the various disciplines which are concerned about alcoholic and drug dependent women and their children. We have responded to hundreds of requests from communities across the nation for assistance in developing appropriate interventions for women and their children. I would hope that we have made some progress in dramatizing the inappropriate and inhumane use of the courts to intervene with women who are impoverished and addicted and who in most cases, have had no access to health and social services which are responsive and sensitive to their needs. I would also hope that we have made some contribution to ending the war on drug users, individuals who suffer from the diseases of alcoholism and drug dependency, which the "War on Drugs" has so clearly become.

Mr. Chairman, we probably would have never needed this coalition if the states had done their job in setting up appropriate treatment for alcoholic and drug dependent women and their children. There has been so much resistance to treating alcoholic and drug dependent women, and especially pregnant women, from every sector of the health and social welfare system in this country. Pregnant women who are alcoholic and drug dependent have been discriminated against when they seek care in many health care and social service settings. I have worked with women who were misdiagnosed for years, treated inappropriately through the mental health system, and finally, when nothing else worked, were referred for alcoholism treatment as a last resort. Women with these problems suffer from such intense stigma that providers have either felt they were undeserving of care or hopeless cases. With few rare exceptions, even the alcoholism and drug addictions treatment programs have failed miserably in their job to provide services for women.

Congress has made several attempts in the past to intervene and support programs for women with addictions. The passage of the women's set-aside of the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant is one example. This legislation required that states spend 5 percent of their ADMS block grant on new and expanded prevention and treatment efforts for alcoholic and drug dependent women. This set-aside requirement was increased in 1988 to 10 percent. Since 1985, the set-aside has represented $364 million that states have been required to spend on services for women.

Despite the presence of a federal requirement since 1984 to devote a portion of federal funds to women, the states' commitment to creating and expanding programs for women has been minimal. The proof of this minimal commitment has become markedly clear in light of numerous reports documenting the virtual absence of treatment programs which serve women and their children, generally, and pregnant women, specifically. Presumably, if states had complied with the spirit and the letter of federal law since 1984, we would have programs operating and would not be in our current crisis. Three hundred and sixty four ($364) million dollars buys a lot of services. Congress specifically identified the need for programs to serve these two populations in the 1984 legislation, and reiterated those priorities in 1986 and 1988.

I know that the states will all argue that they are in compliance with the set-aside requirement. They will point to the numbers of women in treatment as representing over ten percent of their total client population. The fact is that many states are not in compliance. They have used this money to support existing services, they have channeled this money to support 1 "women's group" in an otherwise predominantly male oriented treatment setting, or in one case I am aware of, they simply told all service providers that they must serve 5 percent more women without any increase in funding. The states' failure to implement the set-aside exemplifies the problem that we have had for decades in trying to establish services in this country for women. Women's needs and problems are not viewed as serious and deserving of attention. Tragically, it is only when a woman's ability to bear healthy children is threatened by the consequences of alcoholism and drug addiction that we, as a society, are willing to take notice. We take notice not because we care about women but, because we allege to care about children.

The Coalition has generated many recommendations to enhance the federal response to alcoholic and drug dependent women and their children. Our proposals address programs in the areas of maternal and child health, alcohol and drug treatment, child welfare, education, Indian health services, and housing. We believe that programs must be comprehensive.

There is consensus that efforts should be directed to:
1.) increase access to care including reproductive health care, prenatal care, and alcoholism and drug addictions treatment for pregnant women and women of childbearing age;
2.) increase access to care including medical services, educational programs, and foster care for children with alcohol and drug related birth defects and children growing up in homes where alcoholism and drug addictions are problems: and
3.) increase coordination of programs and services.

In addition, I would like to propose the following very specific, concrete recommendations for your consideration:
1.) Strengthen mechanisms for accountability for the women's set-aside of the ADMS block grant. One option is to require that states use a centralized categorical grant process for distribution of funds. This process was initially used in California where the State Office of Alcohol Programs funded programs directly, instead of channeling funds through the counties, and were successful in establishing a range of new programs for women. Interestingly, the California State Office of Drug Programs disseminated their funds through the county system. There is not the same evidence of new,

discrete services for women as we have with the alcohol programs.

2.) Increase financial support for the Pregnant and Postpartum Demonstration Projects administered by the Office for Substance Abuse Prevention. This demonstration represents the first national effort to establish programs specifically for pregnant women, their infants, and children. The demonstration calls for innovative programs which demonstrate coordination of various disciplines and service providers. A minimum of $50 million should be devoted to this program for Fiscal Year 1991. The program budget for FY 1990 is $32.5 million and the President's budget request for FY 1991 is $37.8 million.

3.) Amend the Special Food Program for Women, Infants and Children (WIC) administered by the Department of Agriculture to expand the category for institutional eligibility to include residential alcohol and drug treatment programs serving women and children. This would provide tremendous support to programs currently serving low-income women who are pregnant, postpartum, and breastfeeding and their infants and children.

4.) Increase access to services for children with alcohol and drug related birth defects and children growing up in alcoholic and drug dependent homes by formally expanding Head

Start eligibility to include infants and toddlers and by increasing financial support for this program to ensure availability of the full range of services needed by these families. Education for the Handicapped programs can be enhanced by increasing federal financial support for specialized instruction and related services under Part B and by enhancing Part H by making it a permanent program, increasing federal financial support to ensure that all states participate, and amending the definition of federal eligibility to include children who at risk of being developmentally delayed, many of whom have alcohol and drug related birth defects.

5.) Where services are being provided in settings serving both men and women, programs who receive federal funds should be barred from discriminating against pregnant women. This should include alcoholism and drug treatment programs, maternal and child health programs, community and migrant health centers, and mental health centers.

Coalition on Alcohol and Drug Dependent Women and Their Children

Organizational Members -- 1990

Alan Guttmacher Institute
American Academy of Pediatrics
American Bar Association - Center on Children and the Law
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Civil Liberties Union
American Medical Students Association
American Nurses Association
American Prosecutors Research Institute
American Psychological Association
American Society of Addiction Medicine
Association of Maternal and Child Health Programs
Center for Child Protection and Family Support, Inc.
Center for Clinical Protection and Family Support
Center for Law and Social Policy
Center for Science in the Public Interest
Child Welfare League of America
Children of Alcoholics Foundation
Coalition on Addiction, Pregnancy and Parenting
Legal Action Center
NAACOG: The Organization for Obstetric, Gynecologic and Neonatal Nurses
National Abortion Rights Action League
National Association of Alcohol and Drug Abuse Counselors
National Association of Perinatal Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Center for Prosecution of Child Abuse
National Council on Alcoholism and Drug Dependence
National Council of Jewish Women
National Parent Teachers Association
National Perinatal Association
National Society of Genetic Counselors
National Women's Law Center
National Women's Health Network
Parent Care
Therapeutic Communities of America
Women's Action Alliance
Youth Policy Institute

NCADD
1511 K Street, N.W.
Washington, D.C. 20005
202-737-8122

Coalition on Alcohol and Drug Dependent Women and Their Children

Statement of Purpose
Passed by Coalition on January 23, 1990

The Coalition on Alcohol and Drug Depdendent Women and Their Children is a group of national organizations concerned about the health and welfare of alcohol and drug dependent women and their families. Coalition members include organizations concerned about women's health care; legal issues; civil rights; child welfare; alcohol and drug problems; and maternal and child health.

Because pregnant drug dependent women have so often faced discrimination, barriers and penalties, the Coalition is concerned about the provision of health and other appropriate services to them and protection of their rights. Therefore, the Coalition is organized to enhance access to preventive and educational services, health care, prenatal care, and alcoholism and drug addictions treatment for women, and to ensure the availability of health and social services for their children. The Coalition believes that the interests of women and their children are best served through the health care and social service systems. Women should not be singled out for punitive measures based solely on their use of alcohol and other drugs during pregnancy.

NCADD
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NCADD POLICY STATEMENT

Women, Alcohol, Other Drugs and Pregnancy

Approved by the Delegate Assembly (April 29, 1990) and adopted by the Board of Directors of the National Council on Alcoholism and Drug Dependence, Inc. (April 29, 1990).

NCADD
National Council on Alcoholism and Drug Dependence
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Summary of the Issue

There has been a great deal of denial about the extent to which women experience alcohol and other drug problems. This denial is even more profound when considering pregnant women. While we have made progress in expanding prevention and treatment efforts to include women, our social and medical institutions have not responded effectively to the needs of pregnant alcoholic and other drug-dependent women. Specific emphasis needs to be given to the development of specialized prevention and treatment for alcoholic and other drug-dependent women of child-bearing age.

Background

There is growing concern throughout our nation about the problems associated with alcohol and other drug use by pregnant women. The advent of crack, a highly and quickly addictive cocaine derivative, has brought these problems into sharp focus and stimulated public debate and discussion about how to respond to the needs of alcoholic and other drug-dependent women and their children. Alcoholic and other drug-dependent pregnant women have become subject to charges of child abuse and prosecution rather than to the support of the health care system. This punitive approach is fundamentally unfair to women suffering from addictive diseases and serves to drive them away from seeking both prenatal care and treatment for their alcoholism and other drug addictions. It thus works against the best interests of infants and children by involving the sanctions of the criminal law in the case of a health and medical problem. Moreover, there is increasing evidence of disparities regarding the screening and reporting of positive toxicologies of newborns, with women of color, poor women and women receiving care in public hospitals having the greatest likelihood of being subject to drug testing and subsequent reporting to legal authorities.

The National Council on Alcoholism and Drug Dependence supports efforts to educate women and their partners about specific risks associated with drug use, including alcohol, tobacco, prescription and over-the-counter medications as well as illegal drugs, during pregnancy. NCADD supports the development of prevention and treatment efforts for pregnant alcoholic and other drug-dependent women and urges policy makers to support measures which will increase access to care and decriminalize the governmental response.

Alcohol- and Other Drug-Related Birth Defects

A great deal is known about the effects of drinking on fetal development. Fetal alcohol syndrome (FAS), the most severe constellation of alcohol-related birth defects, was identified by a team of health professionals in Seattle, Washington, in 1973. FAS is a cluster of symptoms including malformations of the face and skull, growth retardation either before or after birth, central nervous system problems and mental retardation. Fetal alcohol effects (FAE) are a range of birth defects which fall short of meeting the criteria for the full blown-syndrome. Children with FAS and FAE are born to mothers who drank during pregnancy. It is unclear how much alcohol at what time during pregnancy causes the range of problems. The National Council on Alcoholism and Drug Dependence perceives any alcohol consumption during pregnancy as high-risk drinking and supports a clear no-alcohol-use message as the only responsible public health message.

Cocaine use during pregnancy can cause multiple and complex problems in utero and after birth. These problems may include physical anomalies, inadequate development and dysfunction of the body's major organs and systems, including the cardiovascular, neurological and excretory systems. Infants can experience withdrawal symptoms if mothers have used cocaine shortly before delivery. Cocaine use may also cause precipitous delivery resulting in premature birth and problems associated with low birth weight. Sudden infant death syndrome (SIDS) occurs at a higher rate among babies exposed to cocaine.

Babies exposed prenatally to heroin tend to be low in birth weight, short for their age, and have a small head circumference. There is no evidence that opiate drug use by the mother causes malformations like those seen in FAS. Research is continuing in this area. The developing fetus does experience withdrawal as the mother goes through withdrawal. Some postnatal problems of these infants may be due to repeated withdrawals before birth. Newborn infants of opiate-dependent mothers can experience opiate withdrawal symptoms after birth.

Tobacco use during pregnancy can also interfere with healthy fetal development. Babies born to smokers are more likely to be low in birth weight, born prematurely, have lower scores on a standard lack of physical functions, and die within the first year of life. *It is not known exactly how* the ingredients in tobacco smoke affect fetal development. It is known that nicotine smoke reduces oxygen flow to the fetus. It is clear that cessation of smoking during pregnancy will contribute to a positive pregnancy outcome.

There are risks associated with the use of other drugs during pregnancy such as PCP, benzodiazepines and other prescription medications. These risks vary depending on the extent and time of use. In general, all drugs are contraindicated during pregnancy unless deemed absolutely necessary and administered under the supervision of a trained health professional.

Although different drugs have different prenatal effects, the drugs discussed above have some similar effects when they are used during pregnancy. They all tend to contribute to low birth weight. They all may influence the way in which children are able to learn and interact socially. Some cause severe damage, including mental retardation and physical deformities. All contribute to heightened nervousness and irritability in newborns which may impede parent-child bonding and exacerbate post-partum stress for mothers.

It is well-known that the United States has an extraordinarily high rate of infant mortality--one of the highest in the western world. Efforts to reduce the incidence of alcohol and other drug use during pregnancy would undoubtedly contribute to a reduction in infant mortality in the nation.

Treatment for Alcoholic and Other Drug-Dependent Women

A great deal of progress has been made in the United States in our approaches to preventing and treating alcoholism and other drug addictions among women. Prior to the 1970's there were virtually no treatment options for women with alcoholism and other drug addictions. Women rarely came into treatment and when they did, the treatment that they received was based on the male experience of alcoholism with no adjustments for the fact that a woman's life experience and physiology are different from a man's.

The 1970's was a time of dramatic change for women in need of treatment for alcoholism and other drug addictions. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) funded the first wave of women's treatment programs across the nation. Later, in 1984, the women's set-aside of the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant required that states spend 5% of their block grant monies on new prevention and treatment efforts designed for women. The set-aside requirement was raised in 1988 to 10%.

Only a few prevention and treatment efforts have focused specifically on pregnant alcoholic and other drug-dependent women. There are tremendous fears among service providers about liability problems associated with treating pregnant, addicted women. There is also a great need for additional training of treatment providers about how to proceed with safe detoxification and treatment. To date, much of the reaction to treating pregnant alcoholic and other drug-dependent women has been guided by fear, lack of knowledge and lack of experience. The sad irony is that pregnancy offers an opportunity to intervene and provide treatment; yet it is at this very time that the least amount of treatment is available.

The Anti-Drug Abuse Act of 1986 included a provision to establish prevention, education, intervention and treatment demonstration projects administered through the Office for Substance Abuse Prevention for pregnant and postpartum alcohol- and other drug- dependent women. This program has stimulated the development of some of the first programs in the nation to address the needs of pregnant women.

Services for Children

Children born to alcoholic and other drug-dependent women and children living in homes where parents and family members are alcoholic and dependent on other drugs deserve special mention. Children born with alcohol- and other drug-related birth defects often go unrecognized. We need to improve identification and intervention services for these children. They must have access to services for ongoing treatment and special education. Children growing up in alcoholic and other drug-dependent families also need a range of prevention, intervention and treatment services. Intervention and treatment can be powerful tools in preventing future problems for these children. Child welfare services should be enhanced so that alternative living situations are available for children who need temporary foster care and permanent placement. In all cases, efforts should be made to intervene and treat families with the goal of keeping them together if appropriate and possible.

Proposed Policy Recommendations

NCADD supports the development of comprehensive efforts to address the needs of women of child-bearing age and their children. NCADD recommends the enactment of comprehensive policies at the national, state and community levels to improve prevention, education, treatment and research efforts for women. Prevention and treatment programs for women and their children should be sensitive to ethnic and cultural differences among women and employ approaches which reflect sensitivity to the particular needs of the population of women being served. Finally, enhancement of research, prevention, education and treatment initiatives tailored to address the needs of women generally, will undoubtedly reduce the numbers of alcoholic and drug-dependent pregnant women in need of services and ultimately, the number of children born with alcohol- and other drug-related birth defects.

The NCADD Board of Directors, Affiliates and Staff will work towards the enactment and implementation of the following recommendations:

Congress

- Congress should closely monitor the states' use of the 10% women's set-aside of the Alcohol, Drug Abuse and Mental Health Services block grant (ADMS) and insist that this money be spent consistent with the legislation (i.e., new and expanded prevention and treatment services for alcoholic and other drug-dependent women).

- Congress should appropriate additional funds to support the Model Projects for Pregnant and Postpartum Women and their Infants administered by the Office for Substance Abuse Prevention.

- Congress should direct the NIAAA and NIDA to establish a joint research center for alcohol and other drug problems of women.

Executive Branch

- The Office for Substance Abuse Prevention should convene a task force on women, alcohol, drugs and pregnancy with representatives from: the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), the National Institute of Child Health and Human Development, the Office of Minority Health Affairs, the Office of Adolescent Pregnancy Programs and key field representation to coordinate a comprehensive federal response to the health and social service needs of pregnant alcoholic and other drug-dependent women and their children.

- The Office for Substance Abuse Prevention and the National Clearinghouse on Alcohol and Drug Information should develop materials on alcohol and other drug use during pregnancy. Campaigns to disseminate this information to various professional medical and social service professionals should be established.

- The National Clearinghouse on Alcohol and Drug Information should increase efforts to develop culturally and linguistically appropriate materials on alcohol, other drugs and pregnancy for specific underserved groups of women.

- NIAAA and NIDA should support and encourage studies which focus on alcohol, other drugs and pregnancy. Both Institutes should support longitudinal studies on children with alcohol- and other drug-related birth defects. Such defects should be made reportable to establish a data base.

- The Office for Substance Abuse Prevention should convene a national meeting of experts on women, alcohol, other drugs and pregnancy. One outcome of this meeting should be a monograph on state-of-the-art prevention, treatment and research efforts addressing women, alcohol, other drugs and pregnancy.

- The Office for Substance Abuse Prevention should develop written materials and posters which address HIV infection, alcohol, other drugs and pregnancy.

- The Office for Substance Abuse Prevention (OSAP) should develop and disseminate model training programs about identification and referral of women with alcoholism and other drug dependence for health professionals, including nurses and social workers and others who interact with pregnant women.

- The Alcohol, Drug Abuse and Mental Health Administration should require that states report on the number of pregnant women being served in publicly funded prevention and treatment programs as part of their routine data collection efforts. Alcohol- and other drug-related birth defects should be made reportable to establish a data base.

- The Bureau of Alcohol, Tobacco and Firearms should require that mandated health warning labels on alcoholic beverage containers regarding the risks of drinking during pregnancy be clearly legible to alcoholic beverage consumers.

■ The Children's Bureau housed in the Office of Human Development Services of the Department of Health and Human Services should fund grants and contracts that address the issues of foster care placement for children of alcoholic and drug-dependent women.

■ The Justice Department, in collaboration with the Department of Health and Human Services should be required to develop and fund training programs for police and other law enforcement officers on the nature of alcoholism and other drug dependence, intervention processes, treatment principles, and the availability of local treatment resources.

State Legislative and Executive Bodies

■ States should maintain coordination of available health and social service resources to include but not be limited to: Alcoholism and Drug Treatment Programs, especially those agencies which provide services to women and their children; Crippled Children's Services (CCS); Early Periodic Screening Diagnosis and Treatment Programs (EPSDT); Developmental Disabilities services; Special Education programs; Family Planning; Aid to Families with Dependent Children (AFDC) and Women, Infants and Children (WIC).

■ State agencies which manage publicly funded alcohol and drug addiction programs should offer funding for up to three years for demonstration projects which provide services to women and their children with sufficient funds to entice providers to initiate such programs and to allow for adequate start-up time.

■ Each state should develop a task force of state executive branch agencies to coordinate provision of alcohol and drug prevention and treatment services, maternal and child health care, and child welfare services and training to health and social service professionals who serve as gatekeepers to women and their children.

■ States should avoid measures which would define alcohol and other drug use during pregnancy as prenatal child abuse and should avoid prosecutions, jailing or other punitive measures which would serve to discourage women from seeking health care services and which might be offered as a substitute for health care services.

■ States should resist the enactment of laws which identify alcoholism or other drug dependency or alcohol and other drug use as prima facie evidence of child abuse or neglect.

■ States should resist the enactment of laws or regulation which require the automatic removal of an infant from the mother solely on the basis of a positive toxicology screen of the infant.

■ States should appropriate additional funds for the development of comprehensive, multidisciplinary prenatal care and alcoholism and other drug addictions treatment services to pregnant women with alcohol and other drug problems. The continuum of services should include prenatal care, alcoholism and other drug addictions treatment, housing, job training, educational and support services.

■ States should encourage linkages between alcoholism and drug treatment programs and the criminal justice system so that alcoholic and drug-dependent women who enter the criminal justice system can receive appropriate identification, referral and treatment services.

■ States should enact legislation requiring the posting of warning signs at points of purchase of alcoholic beverages alerting the public to the dangers of drinking during pregnancy. These signs should be available in other languages, if appropriate, to meet the needs of ethnic populations.

Research

■ Research is needed on the long-term impact of drug exposure on the health and development of children; comparisons between children raised in foster care to those supported in their biological homes; cost/benefit analyses of the efficacy of various prevention strategies on health and social welfare costs.

■ Research is needed on the male contribution to birth abnormalities related to alcohol and other drug use.

Prevention

■ Schools should offer age-appropriate alcohol and other drug education programs which include specific information on the dangers associated with drinking alcohol, smoking cigarettes, and using other drugs during pregnancy. Appropriate programming for pregnant teens should also be made available in schools.

■ Local governing bodies should offer educational materials on the dangers associated with drinking alcohol, smoking cigarettes, and using other drugs during pregnancy when individuals apply for marriage licenses. These materials should be made available, if appropriate, in languages suitable to other ethnic populations.

■ Schools providing professional education for health professionals should include education and requirements for continuing education on alcohol- and other drug-related birth defects and intervention and treatment of alcoholic and other drug-dependent women.

■ State agencies should offer training on innovative methods to prevent and identify high-risk alcohol and other drug use among women.

■ Health professionals and agencies which provide family planning services should also provide educational materials about alcohol and drug use during pregnancy. Plans for referral to treatment, when needed, should be established.

■ All local health officers who give out marriage licenses should be educated on the subjects of alcoholism and other addictions, and alcohol and other drug use during pregnancy. They should also be provided with educational materials to be distributed to marriage license applicants.

Treatment

■ State and local agencies with responsibility for managing publicly funded alcoholism and other drug addictions programs should offer training for treatment providers on intervening and treating pregnant alcoholic and other drug-dependent women.

■ State and local agencies with responsibility for managing publicly funded alcoholism and other drug addictions programs should ensure that there are an adequate number of residential and outpatient treatment programs with comprehensive childcare components. Treatment programs serving women and their children should be prepared to offer services to the significant others of alcoholic and drug-dependent women, including their male partners.

■ States and local agencies should ensure that physicians and other health professionals providing services to pregnant alcoholic and other drug-dependent pregnant women offer their clients strict confidentiality protections within the confines of existing law.

■ States should resist efforts to weaken confidentiality protections for pregnant alcoholic and other drug-dependent women seeking prenatal care or alcoholism and/or drug treatment services.

■ Whenever possible, individuals including women of child-bearing age and pregnant women, should have the opportunity to receive an evaluation and assessment from an independent community-based referral agency capable of directing them to the most appropriate program.

■ States should utilize mandated prevention funding from their allotment of the ADMS block grant to support prevention, education and intervention aimed at reducing alcohol and other drug problems among women of child-bearing age and at facilitating early intervention for women already dependent on alcohol and other drugs.

■ State and local agencies with responsibility for managing publicly funded alcoholism and other drug addictions programs should withdraw funds from programs which refuse admission to pregnant women.

Child Welfare

■ States should support the development of adequate child protection services to provide alternative placements for infants and children who need to be removed from the care of their parents.

■ Federal and state governments should support the provision of comprehensive health and social services to alcohol- and other drug-affected infants and children, as well as children living in homes with alcoholism and other drug addictions.

■ State alcohol and drug agencies should fund or co-fund staff positions within the child welfare system designated to identify and intervene with pregnant women and parents who are alcoholic and/or drug dependent as well as to educate the child welfare personnel about alcoholism and drug addiction.

STATEMENT OF BRENDA SMITH, J.D., STAFF ATTORNEY, DIRECTOR OF WOMEN IN PRISON PROJECT, NATIONAL WOMEN'S LAW CENTER, WASHINGTON, DC

Ms. Smith. Thank you. I, too, would like to thank you for the opportunity to come here and testify on this issue. I think that it's an important issue, and I've been asked to address the issue specifically of pregnant, alcohol and drug dependent women who are incarcerated, women who are in prison.

First, I'd like to identify myself as Brenda Smith. I'm with the National Women's Law Center. The National Women's Law Center has a long history of work protecting and advancing the rights of women, in particular, low-income women. Just recently, the National Women's Law Center has started a project specifically targeted to incarcerated women because it is an area where many low-income women are finding themselves.

The Center's project started at Lorton Minimum Security Annex in Lorton, Virginia. This is a prison which houses approximately 180 women convicted of violations of D.C. law. Primarily, our project provides legal counseling and services to the women in issues areas that they've identified as priorities: child support, domestic violence, access to medical care and drug treatment.

. What I'd say is that until very recently, the whole issue of women in prison was not given a lot of attention. I think that was primarily because there were very few women in prison. Over the past decade, however, the numbers of women in prison have more than tripled.

In 1980, there were about 13,000 women in state and federal prisons. In 1989, the last time when figures were collected, there were 37,000. In the first six months of 1989 alone, the female prison population grew by 13 percent, compared with a 7 percent growth for the male prison population.

Why are these women here? What are they coming in on? It's primarily on drug offenses. I think that we're seeing such a large increase of the number of women in prison because of the advent of mandatory minimum sentencing. The Federal Bureau of Prisons estimates that about 60 percent of the women who they have in custody are there for drug offenses. Locally in the District of Columbia, it's about 57 percent.

One other thing that I'd like to note before going into the discussion on the issue of drug treatment specifically for women in prison is that there are two things about women that differ in general from men who are in the penal system. First of all, they are there primarily for nonviolent offenses. Statistics show that 53 percent of the crimes which lead to women's incarceration are economic crimes; drug sales, larceny, forgery, theft. That's compared to 39 percent for men. Correspondingly, 55 percent of the men but only 41 percent of the women are in jail for violent offenses.

Another important difference between male and female prisoners, which should be of great concern to this committee, particularly given its emphasis on children, youth and families, is the differing family responsibilities of women prisoners. Eighty percent of women prisoners have children. Of those, 70 percent are single parents. Prior to their incarceration, 85 percent of women prisoners compared to 47 percent of male prisoners had custody of their children.

The other thing that you should know about these women is that they are primarily young women between the ages of 20 and 34, in their child-bearing years. There is an estimate that about 25 percent of the women who are in prisons are either pregnant or postpartum; that is, within 12 months of having given birth.

As I indicated above, many of these women are in the criminal justice system because of drug offenses. Not surprisingly, a large number of these women have alcohol and drug dependency problems.

As early as '79, GAO estimated that between 50 and 60 percent of women prisoners had alcohol and drug dependency problems. These estimates now range between 70 and 80 percent. Notwithstanding this rapid increase in the seriousness of the problem, little has been done in the way of drug and alcohol treatment for women in prisons.

In the past several years, there has been an increase also in the incarceration of pregnant alcohol and drug dependent women, simply because they are pregnant. I won't discuss that issue, but I'll refer you to the excellent testimony of Ms. Moss from the American Civil Liberties Union, who will outline the scope of the problem.

What I will talk about, however, is another disturbing trend, which is the incarceration of pregnant alcohol and drug dependent women on minor criminal charges for the ostensible purpose of protecting their unborn children. A case in point is that of a local woman named Brenda Vaughn, who is a first-time offender on a misdemeanor theft charge.

When she tested positive for cocaine, a local judge here detained her and indicated his intent to detain her until her child was born. Ms. Vaughn remained at the D.C. jail until three days before the birth of her child. While there, even though arguably sent there because of her drug problem, she received no drug treatment, was allowed to detox with no medical supervision, which presents serious health risks for both mother and child and received only spotty prenatal care.

It's clear that whatever the intent was of the judge's sentence, it had only a punitive effect. Ms. Vaughn's situation is typical of what happens in most prisons, where there's been a traditional history of failure to even provide basic gynecological care for women. Just the notion that these prisons, when confronted with pregnant alcohol and drug dependent women, will be able to respond to their needs, it's just not realistic.

The prisons don't have the capability to monitor high-risk pregnancies. They don't have the capability to deal with the increased incidence of sexually transmitted disease and the fact that many of these women are HIV positive. Additionally, the physical setting in most jails and prisons presents serious health risks, particularly for pregnant prisoners.

There is serious overcrowding, poor sanitation and poor dietary maintenance. Generally, the only drug treatment that is offered is Narcotics Anonymous or Alcoholics Anonymous. Even though both of those programs are good and they provide important emotional and peer support for women, they can't provide the serious medical help that many of these women need to detox.

As Senator Wilson indicated, there are several programs which have been successful. He referred to Mandela House and one that I will talk about as well. It's one that is an alternative to incarceration, which is the Houston House in Roxbury, Massachusetts. This is a residential program which serves approximately 15 pregnant prisoners and serves as an alternative to incarceration.

It provides prenatal care, obstetric care, transportation, housing, child care, educational and vocational training, the full range of services which are needed to address the problem.

I would also refer the committee to my testimony which is attached and also to a publication that I prepared on improving treatment for women. What I would say in ending is that there is a serious problem in general for providing drug and alcohol treatment for women in the community.

That problem is even more exacerbated in the prison setting where many of these women are going and where there's been absolutely no response to the needs for the drug and alcohol treatment.

Thank you.

[Prepared statement of Brenda Smith follows:]

PREPARED STATEMENT OF BRENDA V. SMITH, STAFF ATTORNEY, DIRECTOR OF WOMEN IN PRISON PROJECT, NATIONAL WOMEN'S LAW CENTER, WASHINGTON, DC

Good morning. I am Brenda V. Smith, Staff Attorney with the National Women's Law Center and Director of the Center's Women in Prison Project. I want to thank the Committee for inviting me here to talk about the absolute necessity for comprehensive treatment and support services for incarcerated women with alcohol and drug problems. The need is even greater for incarcerated pregnant women who are alcohol and drug dependent.

The National Women's Law Center has worked for seventeen years to protect and advance the rights of women, in particular low-income women. We have been involved in work to improve child support for women and their families, to provide child care, to improve the economic situation of women through the tax laws, to improve education and employment opportunities for women through the vigorous enforcement of Title IX of the Education Amendments of 1972, Title VII of the Civil Rights Act of 1964, and Executive Order 11246 and to secure women's reproductive rights, including the right to terminate a pregnancy and the right to have a healthy child.

More recently, the Center has initiated a project which draws upon its many years of experience advocating for low-income women and their families to provide direct services to incarcerated women. The Center started its model project at the Lorton Minimum Security Annex in Lorton, Virginia. This prison houses approximately 180 women convicted of violations of D.C. law. The goals of the Center's project are to: 1) provide legal counseling information and services to incarcerated women which will empower them to take control of their lives while in prison and enable them to become self-sufficient once they reenter society, 2) to educate women's and other organizations, policymakers and the public about the pressing needs of incarcerated women, 3) to create linkages with other groups and individuals to provide needed services to women in prison and 4) to develop creative and effective responses to the needs of incarcerated women which other jurisdictions can look to as models when responding to similar problems. The Center provides the women with legal counseling and education on issues they have identified as priorities, such as child care, child support, domestic violence and medical care issues. The information I will present today is based both on my work with women prisoners and on research from around the country on incarcerated women.

Until very recently, the issue of women in prison received little attention from the popular press and policymakers. Incarcerated women were, and to a large extent still are, a forgotten population. This was due primarily to the historically small numbers of incarcerated women. Over the past decade, however, the number of women in prison has almost tripled. In 1980 there were about 13,000 women in federal and state prisons.

In 1989, that number had increased to 37,000. In the first six months of 1989 alone, the last date for which figures were available, the female prison population grew by 13 percent, compared with a 7 percent growth in the male prison population.

There are many reasons for this marked increase in the number of incarcerated women. Primary among them is the advent of mandatory minimum sentencing for drug offenses both at the state and federal level. According to the Federal Bureau of Prisons, about 60 percent of the women in federal custody are serving sentences for drug offenses. Locally, in the District of Columbia, 57 percent of women prisoners are serving sentences for drug offenses.

In addition to the fact that the prison population is increasing more rapidly than the male population, there are several other important differences between men and women prisoners which should be discussed. First, women are overwhelmingly convicted of non-violent crimes which arise from economic motives -- crimes designed to generate income, for example drug sales, theft, larceny and prostitution. A 1986 study of all state prison inmates by the Bureau of Justice Statistics founds that drug offenses and property crimes such as larceny, fraud and forgery accounted for 53 percent of the crimes which led to women's incarceration compared to 39 percent for men. Correspondingly, 55 percent of the men but only 41 percent of the women were convicted of violent offenses.

Another important difference between male and female prisoners which should be of great concern to this Committee, given its emphasis on children, youth and families, is the family responsibilities of female prisoners. Eighty percent of women prisoners have children, and of those, 70 percent are single parents. Prior to their incarceration, 85 percent of women prisoners, compared to 47 percent of male prisoners, had custody of their children. I would also note that in my work with women prisoners, the issue of primary concern to them is their children: the status of their children while the women are incarcerated, and the prospect of reuniting with their children after their release. When female prisoners were asked in a 1988 American Correctional Association Survey, who was the most important person in their lives at that moment, 52 percent responded that their child was. These women are primarily young, between the ages of 20 and 34 years old, in their prime child-bearing years. Further, a significant number of women give birth to children shortly before they begin to serve prison sentences, or are pregnant and give birth during their incarceration. One source reports that 25 percent of women in correctional institutions are pregnant or post-partum.

As I indicated above, many of these women are in the criminal justice system because of drug offenses. Not surprisingly, a large number of these women have alcohol and drug dependency problems. As early as 1979, the GAO estimated that between 50 and 60 percent of women prisoners had alcohol and drug dependency problems. The estimates now ranges between 70 and 80 percent. Notwithstanding the early identification of this problem, and its rapid increase in seriousness, little has been done in the way of drug and alcohol treatment for women in prison.

In the past several years, there has been an increase in the incarceration of pregnant alcohol and drug dependent women simply because they are pregnant. I refer you to the excellent testimony of Ms. Moss from the American Civil Liberties Union who has outlined the scope of the problem. The women who are prosecuted are overwhelmingly low-income single women and are predominantly women of color dependent on public facilities for their care. These prosecutions are short-sighted and do not address the roots of the problem: poverty, unemployment and lack of educational and vocational opportunities. Furthermore, they do not achieve their stated goal, namely, putting a stop to drug use by pregnant women. The unintended effects of such targeted prosecutions are to provide a powerful incentive for pregnant women to forego prenatal care and/or drug treatment for fear of either incarceration or loss of their children. As a practical matter, these prosecutions and their effects, which include placing children in foster care and women in jail, burden a correctional system which is bursting to the seams with prisoners, and a social service system which already cannot recruit and retain foster families in numbers sufficient to meet their current needs.

Another disturbing trend is the incarceration of pregnant alcohol and drug dependent women on minor criminal charges for the ostensible purpose of protecting their unborn children. A case in point is that of a local woman named Brenda Vaughan. Ms. Vaughan was a first-time offender on a misdemeanor theft charge for which offenders are routinely placed on probation. Upon finding that Ms. Vaughan had tested positive for cocaine, the judge sentenced Ms. Vaughan to jail, and indicated his intent to make sure that she remained there until her child was born. While at D.C. Jail, Ms. Vaughan received no drug treatment, was allowed to detox with no medical supervision, and received only spotty prenatal care. It is clear that whatever the judge's intent, the sentence had only a punitive effect on Ms. Vaughan, and possibly serious effect on her unborn child which pose significant health risks to both mother and child. It served to expose this woman, who had never previously been incarcerated, to the increased stress of a jail with no evident benefit to her or her unborn child.

The situation in Ms. Vaughan's case is typical of what exists in most prisons and jails in this country where the lack of appropriate medical care for women has been a serious problem for years. Women prisoners have long failed to receive even basic gynecological and medical services. These problems are even more severe for pregnant prisoners who have special medical needs, such as prenatal and obstetric care and increased nutritional needs. Many of these women are also HIV positive or have other sexually transmitted diseases in addition to alcohol and drug problems. They need comprehensive care which is simply unavailable in most prison settings. Until just a few years ago, pregnant prisoners were routinely taken to hospitals to deliver in shackles -- the shackles remained on in many cases even during labor. The lack of adequate medical care for women prisoners has been the subject of litigation all over the country. In California alone, three suits have been brought and settled against large county jails alleging seriously inadequate care for pregnant women, including pregnant alcohol and drug dependent women.

Additionally, the physical setting in most jails and prisons presents serious health risks, particularly for pregnant prisoners and hence for their later-born children. There is severe overcrowding, poor sanitation, and poor dietary maintenance. There is also a serious shortage of comprehensive drug treatment programs. This committee has already heard about the dire shortage of programs for alcohol and drug dependent pregnant women in the community in general. That shortage is even more pronounced in the prison setting. Generally, the only treatment offered is Alcoholics Anonymous or Narcotics Anonymous conducted by volunteers. Though these groups provide valuable emotional and peer support for women attempting to overcome alcohol and drug problems, they do not provide the kind of supervised medical attention many women need to get off drugs.

Several communities have responded to the need for comprehensive drug treatment for pregnant alcohol and drug dependent women. As part of my testimony I have included a publication which I prepared in connection with my work with the Coalition on Alcohol and Drug Dependent Women, which Susan Galbraith has described, entitled "Improving Treatment for Women". In addition to detailing the extent of the problem, it identifies components of successful treatment programs and gives examples of existing programs for alcohol and drug dependent women. I would like to focus briefly on some of the existing programs.

First, all of the successful programs use a multi-disciplinary, multi-pronged approach to providing comprehensive services to women under their care. This includes providing prenatal and obstetric care either directly or through linkages with other agencies, housing for women and their children, childcare, parenting education, counseling, and educational and vocational training. Additionally, these programs have relationships with social service agencies to provide other needed services to women and their children.

One such program that has been very successful is Mandela House in Oakland, California. Mandela House is a residential facility for pregnant alcohol and drug-dependent women and their newborns. The program provides comprehensive treatment, including prenatal and perinatal care and education in child development with an emphasis on the special needs of drug-exposed children. The following services are also offered: transportation, job training, GED preparation, nutrition information, religious counseling, personal grooming, and individual and group drug and alcohol counseling Women live at Mandela House with their infants for twelve to eighteen months. The program accepts women who are involved in the criminal justice system just as it accepts other women.

Another program, this one specifically for incarcerated women, is Houston House in Roxbury, Massachusetts. This residential program serves as an alternative to incarceration for fifteen pregnant prisoners recovering from alcohol and drug dependency. Houston House provides perinatal medical care, treatment for alcohol and drug problems, family services and follow-up counseling. It also assists women in finding employment and housing. Women remain in residence with their infants for eight weeks after delivery and receive counseling for nine months after returning to the community.

The purpose of my discussion of these programs is to highlight that it is possible to provide comprehensive, effective drug and alcohol treatment to women prisoners. These programs are cost-efficient; they cost about the same as incarceration, and their benefits far exceed those of simple incarceration. These benefits include: increased birth weight of babies born to mothers in these programs; a lower percentage of children born with disabilities; and a higher percentage of women in recovery. Because the programs I have mentioned are relatively new, it is still too early to quantify their results. A comparable program, the California Mother Infant Program, which for five years has placed sentenced women with children and infants in community alternatives to incarceration, reports a 20% lower recidivism rate among women who have participated in the program.

I will end my remarks with several recommendations which I believe will improve the quality of drug treatment for pregnant alcohol and drug dependent women in the penal system:

1. Expand community corrections alternatives and residential treatment for pregnant women in prison.
2. Earmark funds for the improvement of medical care for women in state and county prisons.
3. Create specific provisions in drug bills and anti-crime legislation which target funds for comprehensive drug treatment in the prisons specifically requiring coordination of services with non-correctional organisations and agencies such as: maternal and child health, mental health, drug and alcohol and advocates for prisoners and their families.
4. Create and fund model prison programs, using existing successful programs as examples.
5. Encourage state prison systems to use the Women, Infants & Children (WIC) nutrition supplement, which was made available to states last summer.
6. Require adoption of standards similar to those of American College of Obstetrics and Gynecology for medical care for women prisoners.
7. Conduct a study similar to the 1979 and 1980 GAO study on the status of women in prison.

Prepared by Brenda V. Smith,
Attorney, National Women's Law
Center with the help of Jill
Brown, Law Clerk, University
of California, Los Angeles
(February, 1990)

V.

Improving Treatment for Women

Work To Create or Improve Treatment for Women*

The need for change is great.

Alcohol and other drug use among women of child-bearing age has increased dramatically; and thus more pregnant women are faced with alcohol and other drug problems. The only known national estimate suggests that 11% of pregnant women used illegal drugs during their pregnancy. Though pregnant crack-addicted women have received the most media attention, the problem is no less serious for alcohol and other drugs.

Alcohol and other drug use during pregnancy has negative physical and psychological consequences for both the mother and child. Alcoholic mothers are at risk for having infants with fetal alcohol syndrome, which includes mental retardation, growth retardation, and physical differences. Addicted mothers are also less likely than other expectant mothers to obtain appropriate prenatal care and nutrition, resulting in high-risk pregnancies as well as low birth weight babies who are more at risk of infant mortality and childhood disability. These women and their children are also at high risk of AIDS–60% of women and children with AIDS became infected as a result of drug use–and other sexually transmitted diseases. There is also a strong correlation between alcohol and other drug dependence and a number of other social problems such as child abuse and neglect, domestic violence, sexual abuse, and homelessness.

Many Federal, State, and local officials have responded to the problem of increased drug use among pregnant women by seeking punitive sanctions against these women. These sanctions range from criminalizing drug use during pregnancy to placing newborns who test positive for drugs at birth, along with existing siblings, in the custody of the State. These punitive measures are ill-considered and short-sighted and will deter pregnant addicted women from seeking prenatal care for fear of negative consequences.

There is consensus among advocates, health care professionals, and child and family welfare experts that pregnant women with alcohol and other drug problems need comprehensive treatment services that take into consideration the complexity of addiction as well as the medical, psychological, and economic needs of women and their children.

Unfortunately, alcohol and other drug treatment programs that address the needs of women and their children are distressingly scarce. Even fewer treatment programs serve pregnant addicted women. A survey of existing drug treatment programs in New York City found that 54% refused to treat pregnant addicted women, 67% refused to treat pregnant addicts on medicaid; 87% denied treatment of pregnant women on medicaid addicted specifically to crack. Less than half of the programs that did accept pregnant women made arrangements for prenatal care and only two provided child care, although it is well established that both are essential for successful intervention.

What can you do?

There is widespread agreement that successful treatment programs for pregnant addicted women should use a coordinated multi-disciplinary approach and provide a range of services targeted at not only the addiction or abuse, but at increasing the self-esteem and independence of the mother and at strengthening the bond between mother and child. Components of successful treatment programs for pregnant alcohol or other drug-dependent women include:

1. Formal linkages with appropriate medical care for mother and child which take into account the effects of addiction:
    - Obstetric and gynecological care including screening and treatment for AIDS and other sexually-transmitted diseases
    - Perinatal care
    - Pediatric care for children (newborns, infants and toddlers) including developmental assessment
2. Alcoholism and Other Drug Addiction Treatment and Counseling by staff sensitive to cultural, social, and emotional needs of women clients.
3. Facilities to allow newborns and or existing children to live with mothers during treatment.
4. Child care for newborns and existing children (particularly important in outpatient treatment programs).
5. Services provided on sliding fee scale basis with medicaid funding accepted.

6. Confidentiality of patients medical history and treatment unless permission of patient secured.

7. Parenting/child development education.

8. Vocational and educational training, counseling and referral.

9. Transportation to center and other appointments (particularly important in outpatient programs where pregnant addicted women may lack incentive to come to program and where treatment program may be far from woman's home).

10. Supportive services

    - Housing

    - Public Benefits
        - Housing Assistance
        - Medicaid
        - Child Care
        - Food Supplements (such as WIC)
        - Energy Assistance
        - AFDC Benefits
        - Food Stamps
        - Services for Children with Disabilities
        - Transportation

    - Counseling
        - Domestic Violence
        - Sexual Assault
        - Child Abuse and Neglect

    - Support Groups

11. Aftercare component for both mother and child.

12. Mental health services.

13. Coordination with social service agencies.

Some Existing Programs for Pregnant Addicted Women

EMO/ARA Women & Children's Recovery House
807 S.E. 28th Street
Portland, OR 97214
Contact: Nancy R. Anderson, Administrative Director
(503) 231-9712

Opened in May 1989, the EMO/ARA Women & Children's Recovery House provides residential drug and alcohol treatment for women, including pregnant women. Women and their children, up to age 8, live at the facility, which can house a total of nineteen women and children. In addition, the Recovery House holds weekly after-care sessions for program graduates. Women undergo a twelve-step recovery program and attend classes designed to build their self-esteem and teach parenting skills. Although most of Recovery House's residents are indigent, those who can afford to pay do so according to their income. The program is funded in part by the Oregon Department of Corrections, the remainder by private funds.

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Houston House
9 Notre Dame Street
Roxbury, MA 02119
(617) 445-3066
Contact: Social Justice for Women
Marianne Galvin, Director of Development
(617) 482-0747

This residential program located in Roxbury serves as an alternative to incarceration for 15 pregnant women recovering from alcoholism and other drug addiction. Houston House provides perinatal medical care, alcohol and other drug treatment, family services, and aftercare services. The program also assists women in finding employment and housing. New mothers and their infants live at Houston House for 8 weeks after delivery and receive counseling for up to 9 months after reentering the community. Houston House is funded by the Massachusetts Department of Corrections along with private funds.

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Jefferson Family Center
111 S. 11th Street, Suite 6195
Philadelphia, PA 19107
Contact: Loretta P. Finnegan, M.D., Director
(215) 928-8577

The Jefferson Family Center, located at the Thomas Jefferson University Hospital, is an outpatient treatment program for women, including pregnant women, who are alcohol or other drug-dependent. It provides obstetric and gynecological care, psychological counseling, and inpatient detoxification. The Center also treats infants born to alcohol and other drug-addicted mothers and offers family counseling services.

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Mandela House
P.O. Box 19182
Oakland, CA 94616
Contact: Minnie Thomas, Director
Rita Nelson, Assistant Director
(415) 482-3217

Mandela House is a residential facility for pregnant alcohol- and drug-dependent women and their newborn children. The program provides comprehensive treatment, including prenatal and perinatal care and education in child development, with an emphasis on the special needs of drug-exposed children. The following services are also offered: transportation, job training, GED preparation, nutrition information, religious counseling, personal grooming, individual and group drug and alcohol counseling. Women live in Mandela House with their infants for twelve to eighteen months. The program is funded by a combination of county and private funds.

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New Day of C.A.S.P.A.R.
242 Highland Avenue
Somerville, MA 02143
Contact: Norma Finkelstein, Director
Eileen Brigandi
(617) 628-8188

New Day is a residential program for pregnant women who have undergone detoxification. The facility can accommodate ten women and their infants up to 6 months after delivery. Individual, group and family counseling, alcohol and drug education, educational and vocational counseling and referrals, and parenting and child development classes are offered. Prenatal and obstetrical services are provided off-site by local hospitals. New Day also works with the Somerville Housing Authority to locate housing in the community. Funded primarily by the Massachusetts Department of Public Health, the program also derives some income from those of its residents who can afford to pay.

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Odyssey House Family Center
666 Broadway, 10th Floor
New York, NY 10012
Contact: Benjamin Walker, Jr., Chief Executive Officer
William Stone, Research Associate
(212) 477-9493

Odyssey House operates the only long-term residential treatment program in New York State for drug-addicted parents and their children. At the Family Center, pregnant women and parents with children up to age five spend approximately twelve to eighteen months in residence. The program offers prenatal and postnatal care, pediatric services, day care, educational and vocational services in addition to drug and alcohol treatment. Odyssey House provides aftercare services to graduates of the program.

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The Perinatal Center for Chemical Dependence
Northwestern Memorial Hospital
Chicago, IL 60601
Contact: Ira Chasnoff, Director
LaVon Coate
(312) 908-0867

The Perinatal Center for Chemical Dependence is a hospital-based, outpatient clinical research program that integrates alcohol and other drug abuse treatment and counseling into prenatal, postnatal, and pediatric medical care. A large interdisciplinary staff provides case management, prenatal care, social work services, outpatient alcohol and other drug abuse treatment and counseling, parenting skills, support groups, and extensive newborn and pediatric follow-up, including medical care, developmental testing, and physical therapy. Pregnant women are asked to commit to the program though 1 year postdelivery.

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* Developed by the Prevention/Education Committee of the National Coalition on Alcohol and Drug-Dependent Women and Their Children, with special thanks to the National Women's Law Center.

STATEMENT OF NEAL HALFON, M.D., M.P.H., DIRECTOR, CENTER FOR THE VULNERABLE CHILD, CHILDREN'S HOSPITAL IN OAKLAND, ASSISTANT CLINICAL PROFESSOR OF PEDIATRICS AND HEALTH POLICY, DEPARTMENT OF PEDIATRICS AND INSTITUTE FOR HEALTH POLICY STUDIES, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CA

Dr. HALFON. Chairman Miller, thank you once again for inviting me back to the Select Committee. My name is Neal Halfon. I'm Director of the Center for the Vulnerable Child at Children's Hospital in Oakland. I'm a practicing pediatrician with responsibility for a large foster care clinical program that is currently caring for over 100 drug-exposed babies and also responsibility for the Center of Care that cares for drug-exposed babies and their chemically-dependent mothers.

Today I'm going to be talking about the policy and training issues that need to be addressed in order to continue to attend to the problem as it continues to escalate. What we have seen over the last several years is that the challenges to service providers are increasing as more and more women come into the system. These are systems that are already overloaded. We have a crisis of both organization and funding.

Furthermore, we have an insufficient understanding of what constitutes an appropriate response to this problem, (although we would have sufficient information to begin to act). We do not have the necessary personnel with appropriate training to respond to this crisis.

There seems to be an emerging consensus by a diverse group of providers that because chemically dependent women and their drug exposed babies have multiple service needs, that the models of care should include a full continuum of services from residential services to outpatient services; that we need to have sufficient intensity of services; that we need to provide a multi-disciplinary approach; that it is better to provide "one-stop-shopping" models and that we want to use therapeutic case management as much as possible as the glue to hold this diverse set of services together and to support the multiple needs of the children and family.

In order to get a better sense of what was going on around the country, we conducted an informal telephone survey in the summer of '89. This survey was not done in a statistically rigorous way. We sought out what were considered model programs around the country, the ones that were in the press, and the ones that other providers were talking about. These were all outpatient programs rather than residential programs.

All were attempting to provide the continuance of services as necessary. I have provided you with the results of the survey of the ten programs. One of the results is that the funding for these services—and these were in several states, including New York, Philadelphia, Florida, California and Illinois—the funding sources for these model programs were coming from a very diverse set of sources. Funding came from different block grants, different state and federal funds from OSAP and NIDA and were put together in a rather hodgepodge patchwork, which was obviously difficult for the service providers to sustain. In fact, when we talked to the directors of these programs, much of their effort was going into just keeping their programs alive rather than spending the time that was needed to perfect and further develop their services.

As you can also see from our survey, only four of the ten provided a full comprehensive range of services, providing both pre- and postnatal care. So it was very difficult for them to amalgamate the kinds of services that were necessary to perform due to limitation in funding.

All the programs surveyed had remarkably similar goals: decreasing maternal drug use, lowering drug-related infant mortality, reducing barriers to needed services, promoting family reunification. The clienteles were also very similar: poor women, mostly of minority backgrounds, inner-city inhabitants, primarily using crack and cocaine, with the history of physical and sexual abuse, and with the history of parental drug and alcohol use in their families.

The services in all these centers were similar also. They emphasized a continuum of care. They tried to provide a wide range of services from medical and psychosocial as well as practical support services. These were not residential treatment programs but were outpatient programs trying to take care of women still living in the community.

They all emphasize case management with similar roles and activities for the case managers: not only acting as brokers and organizers of care but also acting as therapeutic agents in order to help women hold their lives together as they went through the up and down recovery process.

They had a greater emphasis on addressing psychosocial and developmental needs of both the women and the children, rather than just serving the medical needs. I do not think a medical model is an effective way to approach this problem. We need a much more expanded ecological public health model.

We also found that there were a number of barriers in each one of these programs to providing effective services. There was difficulty in recruiting and retaining good staff. The issue of burnout with this population of service providers was mentioned by all the program directors.

It was very difficult, as I mentioned, to find long-term funding for specific needs and facilities. Importantly, the client's needs are not well served by other community resources. When trying to maintain a woman in her community, it's very difficult to find housing, transportation, and other residential drug treatment programs for her.

There was also identified a lack of knowledge on how best to improve outcomes and problems with health and social service agencies. Often, the service providers were in conflict with other county and local agencies. They also identified real problems in interagency coordination. They found that other providers were particularly ignorant of the problems of these women, especially medical providers, which I'm sorry to say as a representive of the medical profession.

I want to make several suggestions on how we might begin to address some of these issues from a policy perspective and what Congress might seek to do. If we want to continue to develop family focused, community-based models, that emphasize a multidisciplinary approach and try to mobilize a broad set of community resources, we're going to have to develop a sustainable funding base for multidisciplinary community-based programs for perinatal substance abuse.

This is going to be hard to do because current Federal funding represents patchwork programs. I think that one example of what Congress might do is to mandate, through the next Budget Reconciliation Act, facilitating a way of combining Title XIX (Medicaid) EPSDT services, the ADAMHA block grants, along with MCH block grant services. This would be analogous to changes Congress mandated in OBRA 1989 that made Medicaid more accessible, EDSDT more expansive, and linked to WIC. I think that this would help service providers pull together the service packages needed to meet the multiple needs of this population.

Congress needs to continue to fund geographic demonstration projects. OSAP needs to be commended on the job that they've done in the last year in really supporting these kinds of projects. There is also a need for more evaluation and more treatment exploration. Further funding into what constitutes basic and appropriate treatment for this population is sorely needed from both the basic science and the clinical perspective.

We need to continue to develop family resource models. Preliminary evidence from other fields on community-based family resource centers where all services can be provided under one roof hold great promise, but there's been very little funds applied to the development of these kinds of programs for chemically dependent pregnant and parenting women.

We also need to spend more time looking at case management. Case management is something that's been touted as the panacea for all problems in almost every human service system. Yet, we have very little research on what case management is, how it works, how it should be reimbursed. In 1986, this body allowed states to fund case management through Medicaid. However, very few states are taking advantage of that option, an important strategy for using the Title XIX services to fund case management for these women.

Examining the role of case management in a much more serious way is something that could be done through the Agency for Health Care Policy and Research.

One corollary: Because this is a big and growing problem with a diverse set of effects, we need to call upon agencies within the federal government that can add to this effort. For example, the Agency for Health Care Policy and Research is receiving from Congress over $250 million to look at the effect of coronary angioplasty and other kinds of medical interventions because health care costs are going out of sight. The efficacy of case management and other services for chemically dependent women needs to be investigated with the same kind of rigor as other kinds of medical interventions. AHCPR could provide great help in that regard.

The CDC should be brought into this problem in a more effective way than has been done in the past. They've been involved in a variety of other addictive behaviors like smoking and alcohol, but they're not really very much involved in this problem at the present time. We need much better population-based data than we currently have. Estimates that are quoted can both over and undershoot what the actual nature of the problem is.

Congress needs to also support the efforts that have begun this year between agencies like NIDA and NIMH, NIDA and MCH, OSAP and MCH: where agencies are combining efforts and funding to address this problem.

Population-based strategies also need to be investigated. One of the things we do not do that is seriously hampering our efforts, is population-based program evaluation.

We do not know whether the same 20 percent of women are recycling through programs while 80 percent are not getting services at all. I think if we're going to really have effective family-focused, community-based programs, we need to take a much more population-based approach. Again, the CDC might be helpful in planning such a study.

From a training standpoint, although we emphasize these wonderful pie-in-the-sky multidisciplinary approaches where doctors, social workers, psychologists, child protective services workers, and lawyers can all work together, we do not yet have the ability to train people to work together.

Being someone who has worked for the last several years as part of a multidisciplinary team, I'll tell you it's much, much more difficult to mount and sustain than one would think. If we are going to embark and really dig in for the long haul with this problem, we need to really support the development of multidisciplinary training centers around the country.

Such multidisciplinary training centers could be both university and community-based and be provided with grants to provide the multidisciplinary training needed to support the kinds of community programs that need to develop.

When I say multidisciplinary training centers, I am not just talking about traditional training grants funded by NIH or the Department of Health and Human Services. I'm talking about centers that can actually be provided core support over the next five to ten years to serve both the research and training in this area.

It's clear that the training effort demands more coordination, bridging disciplines that are trying to work together at the present time and are having a very difficult time, and bridging the efforts between the educational institutions and the community providers.

We also need to provide support for continuing education amongst professional societies. I know that when I talk to colleagues in the legal area they ask me, can doctors really be educated about this problem? Can OB–GYNs be educated about this problem?

I had the privilege of participating for the last couple of years in a process that I think serves as a good model for this. That was an effort that was created by the Academy of Pediatrics and the Child Welfare League of America to look at standards of care for children in out-of-home placement.

This process brought together several disciplines to determine the standard of care for this group of kids. We had to sit down and put some of our disciplinary biases aside, yet rigorously determine standards. Those standards then were taken back to states and professional organizations on a statewide level for implementation.

This process served to initiate legislation in the State of California and to further cause a coalition to develop around the issue of health care for foster children. I think the same kind of process could be developed for professional organizations and for continuing education around the issue of chemical dependency and perinatal drug abuse, and that Congress could provide grant support and contract support for these professional organizations to encourage this process.

[Prepared statement of Neal Halfon follows:]

PREPARED STATEMENT OF NEAL HALFON, M.D., M.P.H., DIRECTOR, CENTER FOR THE VULNERABLE CHILD, AMBULATORY SERVICES, CHILDREN'S HOSPITAL, OAKLAND; ASSISTANT CLINICAL PROFESSOR OF PEDIATRICS AND INSTITUTE FOR HEALTH POLICY, DEPARTMENT OF PEDIATRICS AND INSTITUTE FOR HEALTH POLICY STUDIES, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CA

Chairman Miller, Members of the Committee - thank you for inviting me back to address the Select Committee on the need for new research and training initiatives in order to deal with the problems of perinatal substance abuse. I am a practicing pediatrician and the Director of the Center for the Vulnerable Child, a multidisciplinary, clinical service, research, and policy center at Children's Hospital in Oakland, California.

The increasing number of chemically dependent women and their drug-exposed infants have confronted service providers in health, mental health, chemical dependency, social welfare, and education with a new set of challenges. This new set of challenges has stressed an already overburdened system with a growing population of clients with multiple service needs. What this crisis has shown us is that our models of service delivery - including organization and funding - are inadequate to meet the needs of this population; that our understanding of what constitutes an appropriate response to this problem is inadequate; and that we lack the necessary personnel with appropriate training to respond to this crisis.

There seems to be an emerging consensus among a diverse group of providers, that because chemically dependent women and their drug-exposed babies have multiple service needs, models of care should include: 1) a full **"continuum of services"** - for prenatal to postnatal care with an **emphasis** on prevention; 2) that this continuum of services be of **sufficient intensity** to reach a difficult population **utilizing a multidisciplinary approach**; 3) that services be centralized as much as possible to promote "one stop shopping"; 4) that **therapeutic case management** serve as the "glue" that holds these diverse services together, supporting the multiple needs of these clients and families.

For a better understanding of how services are currently being provided, Wendy Jameson and other members of our staff conducted a small telephone survey of ten model programs nationally that deliver a combination of medical and social services to chemically dependent women and their children. This survey was conducted in Summer, 1989 and predates new program initiatives by the Office of Substance Abuse Prevention that were initiated in 1989 and 1990. These surveyed programs were comprehensive outpatient programs and focussed on the mother and the child. Programs were identified through the literature, press, and through other providers and were selected because they were "model programs", i.e., those programs that may be unusual in terms of their comprehensiveness, their emphasis on treating the whole family, and their widespread reputations. This descriptive information generated from this limited survey allows us to answer questions of what programs do, whom they serve, and what can realistically be expected for such programs to accomplish. Table 1 (Page 3A) lists the primary funding sources - i.e., the largest core grant - for each program surveyed. For each program, primary funding comes from either local, state or federal government. Often federal funds come in the form of 2 - 3 year demonstration grants with no guarantee of continued support after that time period. This pushes organizations into a transitional period where they must find alternative sources of funding or go under. Table 1 also shows that only four programs able to serve clients comprehensively as of Summer, 1989 were providing both prenatal and postnatal services. The remainder of the programs provided either prenatal or postnatal services only.

Table 2 (Page 3B) illustrates the range of services provided by the programs surveyed. This list includes only those services provided by program staff, not those for which clients were referred. Although most programs attempt to house as many services as possible under one roof, this is a difficult goal to meet. If a program does not provide a service on site, such as medical care or drug treatment, they would refer clients out for followup through a case management process.

TABLE 1: CHARACTERISTICS OF PROGRAMS SURVEYED

Program	How long in existence	Primary funding source	No. of clients[1]	Prenatal/ postnatal
PAAM	1975	NY State Division of Substance Abuse	500	Both
Star	Jan., 1989	Robert Wood Johnson Foundation	15-20	Post
Eden	1987	AB 1733[2] and county drug funds	97	Post
PAR	June, 1988	OSAP	28 children	Post
Family	1970	NIDA/ODAP/CODAP	100-120	Pre[3]
PCCD	1976	NIDA	330[4]	Both
FACET	1979	City/county drug funds	60	Both
HIP	Feb., 1988	County funds/ MCH block grant	151	Post
UCLA	1983	AB 1733	20-25	Both
CARE	1987	Stuart Foundation & CA Dept. of Develop. Services	50	Post

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1. Unless otherwise stated, the term "client" refers to a mother-child dyad, possibly including the father.
2. This legislation provides child abuse prevention funds to a few programs serving children at risk of abuse of neglect.
3. This program provides a few infant services as well.
4. Their clientele are comprised of 30 pregnant women and 300 infants and toddlers.

TABLE 2: SERVICES PROVIDED BY PROGRAMS SURVEYED

	PROGRAM									
SERVICE	PAAM	Star	Eden	PAR	Family	PCCD	FACET	HIP	UCLA	CARE
Prenatal med.care	X				X	X	X		X	
Ped. med. care	X			X	X	X	X		X	X
Social service case mgmt.	X	X	X	X	X	X	X	X	X	X
Methadone maint.	X			X	X		X			
Detox.	X			X	X		X			
Drug counseling	X		X	X	X	X	X	X	X	X
Parent ed.	X	X	X	X	X	X	X	X	X	X
Home visits	X	X	X	X				X	X	X
Child care	X		X	X	X		X			X
Drop-in center	X		X				X			X
Support groups	X		X	X	X	X	X	X		X
24-hour hotline	X		X		X				X	
Community outreach	X	X	X	X	X	X		X	X	X
Child develop.	X	X	X	X	X	X	X	X	X	X

Although each of the programs surveyed has a different organizational and staffing history, we found surprising commonalities. See Table 3 (Page 4A). An explicit goal of each program is the reduction of maternal drug use and of child mortality and morbidity resulting from drug exposure. Each program also attempts to keep mothers and children together whenever possible, using a community-based, family-centered approach to serving their clients. From this ecological base, programs attempt to provide for the women's and child's medical, psychological, and practical needs from birth till the child becomes a toddler. The focus of most of the programs are more on psychosocial needs than medical concerns.

The programs surveyed appear to use case management in remarkably similar ways. Case managers function as organizers, brokers, and advocates as well as counselors and therapists. Similarly, these programs operate in ways to maximize the coordination of services, with an emphasis on inter-agency coordination. Seven of the ten programs surveyed coordinate their efforts with other agencies on some level, either by becoming a member of a community inter-agency council or by creating regular meetings with other agencies. Service coordination focuses on improving direct client services, and on providing a forum for program directors to exchange ideas and establish referral networks, to decrease duplication and fragmentation, and to bridge gaps.

TABLE 3: COMMONALITIES AMONG PROGRAMS SURVEYED

Goals:

- Decrease maternal drug use
- Lower drug-related infant mortality and morbidity
- Reduce barriers to needed services
- Promote family reunification
- Utilize an ecological approach -- individual, family, and environmental interventions

Clientele:

- Minority
- Poor
- Inner city inhabitants
- Primarily using crack cocaine, although polydrug use is common
- History of physical and sexual abuse
- History of parental drug and alcohol use

Services:

- Emphasis on continuum of care -- prenatal to the child's early years
- Provision of a wide range of services providing medical, psychosocial, and practical support
- Importance of case management, with similar roles and activities for case managers across programs
- Greater emphasis on addressing psychosocial and developmental needs of women and children than on serving their medical needs

Interagency coordination:

- Interagency councils
- Regular interagency meetings

Lack of program evaluation:

- Programs are too new to have any results yet
- Evaluation consumes only a minimum amount of resources
- Lack of funds to support evaluation

Every program except one conducts some type of an evaluation, ranging from very extensive research to simply counting the number of clients seen. Six programs are involved in extensive evaluation efforts, but only one has reported outcomes so far; most programs are too new. Most program directors report that typically their funding does not cover evaluations.

Table 4 (Page 5A) illustrates several barriers to the achievement of program goals as reported by the program directors. Many feel that the clients are not as well served as they should be. Each program director was quick to praise the dedication and quality of their staff, yet they also cited problems in recruiting and retaining good staff. As one program administrator stated, "It is difficult finding good, committed staff who are willing to work with drug addicts for low wages and in bad neighborhoods."

Another obstacle is the lack of knowledge about how best to help this population. Even those who work daily with chemically dependent women and their children do not feel completely secure in the knowledge of what services these children and families need. Moreover, they feel that other service providers with whom their clients come in contact are particularly ignorant of the special problems of drug addicted families. This insensitivity to the real needs of these high risk families is a fact that we encounter on a daily basis even in our own institution where we attempt to educate our colleagues in a formal way.

TABLE 4: OBSTACLES TO EFFECTIVE SERVICE

- Difficulty recruiting and retaining good staff
- Difficulty finding long-term funding and funding for specific needs such as facilities
- Client's needs are not well served in the community -- housing, transportation, and residential drug treatment needs remain unmet
- Lack of knowledge on how best to improve outcomes for chemically dependent women and children
- Problems with the health and social service delivery systems, producing gaps through which clients fall

Finally, respondents cited inter-agency problems that hinder their efforts. These include conflicts with welfare departments over when to remove children from their mothers, a lack of uniform policies across agencies regarding service delivery, and a lack of criteria for quality and intensity of services to be provided. Since very few standards of care exist, it is difficult for service providers from different disciplines to have an agreed upon point of reference when conflicts in service provision develop.

POLICY IMPLICATIONS

It is important to continue the development and evaluation of family-focused, community-based models. These types of models are difficult to mount and sustain since they require a multidisciplinary approach (i.e., physicians, drug-treatment experts, psychologists, child welfare workers, lawyers working together) and the mobilization of a broad set of community resources (i.e., housing, drug treatment, medical and social services, jobs, etc.). Evaluation of such model programs must be rigorous and multidimensional and enlarged support of training will be key.

PROGRAM DEVELOPMENT AND EVALUATION GOALS

1. Develop a sustainable funding base for multidisciplinary community-based programs for perinatal substance abuse.

Current program administration in programs addressing this problem is often directed towards sustaining the complicated patchwork of funding from different community, state, and federal agencies with few guarantees, instead of focusing on program development and improved quality of services. Fragmented categorical funding exacerbated by the necessity to blend services from different funding streams makes the goal of sustainable funding even more difficult. Congress could move to simplify funding requirements and develop new mechanisms to assure funding of key services - like prenatal care, case management, drug treatment, and child development services.

2. **Continue to fund geographical demonstration projects with additional funding for intra program evaluations.**

The Office of Substance Abuse Prevention (OSAP) has done a commendable job of developing new demonstration projects around the country. These efforts should be further supported and expanded with additional funds targeted towards inter program evaluations of programs with similar approaches.

3. **Develop family resource models.**

There is preliminary evidence from other fields that community-based, family resource centers, where all services can be provided under one roof (i.e., one-stop shopping model) hold great promise. Development of such models should be supported.

4. **Case management approaches must be subject to rigorous evaluations.**

Case management is defined and employed in diverse ways. Since case management has been touted as an essential therapeutic intervention, not just for case monitoring and eligibility determination, it should be subjected to as rigorous outcome evaluations as would be employed for a therapeutic intervention, like angioplasty to unclog blocked coronary arteries. The role, efficacy, and outcomes of case management should be examined both within and across programs, similar to the way that the Agency for Health Care Policy and Research (AHCPR) will be examining the efficacy of other clinical interventions.

COROLLARY

A variety of divisions of the Department of Health and Human Services have expertise that could be brought to bear on this problem. As mentioned, the Agency for Health Care Policy and Research (AHCPR) could be involved in outcome evaluations and program effectiveness evaluation similar to their efforts with other health interventions. The Centers for Disease Control could be more involved in monitoring and prevention efforts like they are with other addictive behaviors, i.e., smoking cessation. The Bureau of Health Care Professions could be more involved in training efforts, etc. Similarly, current efforts towards cross agency collaboration should be supported. Recent efforts by the National Institute on Drug Abuse (NIDA) and the National Institute of Mental Health (NIMH) to jointly sponsor projects on the mental health of the drug using population and collaborations between NIDA and the Division of Maternal Child Health are examples of new collaborations that merit expansion.

5. **Population based strategies should be developed to evaluate the impact of therapeutic programs.**

Often the focus of outcome evaluation is directed at individual clients rather than the entire population that is at risk. If the same 20 percent of people are recycled through drug treatment programs in a particular city the behavior and outcomes for the other 80 percent of the population that don't receive treatment is unknown. If family-focused community-based services are to be successful this type of population evaluation is essential. Again, the CDC might be very helpful with such an approach.

TRAINING GOALS

While there are examples of good treatment programs for pregnant and parenting drug using women, the new models under development require a new breed of providers with new skills. In addition, many current providers need additional training to meet the needs of these high risk children and families. The creation of multidisciplinary approaches requires professionals to work together in unaccustomed ways. Multidisciplinary approaches, with continuous supportive services, have been regarded as highly successful, but they are difficult to mount and sustain. As one who has worked in such a center for the past three years, I can personally attest to how difficult it is for a physician, with all the inherent biases and training in that discipline, to work as part of such a team.

1. **Develop multidisciplinary training centers.**

In order to instill providers with appropriate knowledge and skills and to support the personal attributes that permit one to work in a very demanding situation without burnout, new models of training must be developed. Since the goal of these programs is to combine the efforts of social workers, psychologists, drug treatment experts, pediatricians, obstetricians, family practitioners, lawyers, program administrators, and others - they must be trained together and not at cross purposes.

University-based training grants have been used in the past as a means to support the development of new expertise. Other types of training grants will also be needed to train the types of personnel needed to meet the challenges of perinatal substance use. Major objectives of such training programs should be that training is **inter-disciplinary** and **provides a bridge between educational institutions and community providers.** Such training centers will need ongoing core support, and this core support can provide an important resource to sustain efforts that many communities will need. Multidisciplinary training centers could be developed through grants made available to university - community - health center consortiums. Similar centers have recently been supported by the Administration for Children, Youth, and Families (ACYF) grant programs to support university-based child abuse training centers.

Additional funds should be made available to develop relationships between academic institutions and community providers. Such programs could be used to improve coordination efforts and to provide incentives for university faculty to engage in the applied research and evaluation needed to support the efforts of community providers.

2. **Support continuous education programs through professional societies.**

For professionals already in the field, Congress could support continuing education of individuals through national, state, and local professional organizations. This process could be facilitated by bringing together national professional organizations to discuss and develop standards of care for these needy populations. Such a process is important because it supports the development of consensus across disciplines with regard to what constitutes appropriate care, and provides needed benchmarks in the field that currently do not exist. A recent example of such an effort was conducted by the Child Welfare League of America and the American Academy of Pediatrics in order to develop standards of care for children in out-of-home placements. These two national professional organizations convened a multidisciplinary national task force to address this shared issue. The standards developed by this task force and published by the Child Welfare League of America are now in the process of dissemination to states around the country. In California, a state level task force was convened to adapt these national standards to the state level and to organize the efforts of several different professional groups to implement the standards locally. Similar efforts could be supported by Congress through contracts and grants to national, state, and local professional organizations.

STATEMENT OF DAVID GATES, J.D., STAFF ATTORNEY, NATIONAL HEALTH LAW PROGRAM, INC., WASHINGTON, DC

Mr. GATES. Thank you, Mr. Chairman, and thank you for inviting me to testify today on this critical problem. My name is David Gates. I'm a staff attorney with the National Health Law Program. Prior to that, I was a legislative assistant for State Senator Roxanne Jones from Pennsylvania.

I'm here today to testify concerning the Medicaid program. This is a federal program which should be playing an important role in providing that sustainable funding base that Dr. Halfon just spoke about but, in fact, is not. I would specifically like to bring to your attention that this is a program created by Congress. Therefore, the problems can, in fact, be corrected by Congress. So there is good news in that regard.

The Medicaid program is already spending millions of dollars on the effects of maternal addiction. So, the real question when we discuss Medicaid is not whether we should spend the money on substance abuse but rather, are we getting the most for the money we are now spending? I say that we are not.

Most of the money spent under Medicaid right now is being spent on neonatal intensive care, trying to fix a problem after the damage is done at a cost of $30,000 per baby, according to Senator Wilson's figures. The rest of the Medicaid money is generally spent on hospital detox and methodone maintenance.

Now, detox, although it is a critical first step in the continuum of treatment, is not treatment in and of itself. So what you find is people being detoxed under Medicaid and then put back onto the street without an ongoing treatment plan because the funding stream stops at the hospital door.

Methodone is simply not appropriate for alcohol or cocaine addiction which are the primary drugs of choice for women today. So, for a large segment of the pregnant substance-abuse population, methodone is just simply inappropriate.

Coverage of out-patient treatment is extremely uncertain under Medicaid. The federal agency that administers Medicaid, the Health Care Financing Administration, has really not given a whole lot of guidance to the states on this matter. Coverage of non-hospital residential rehab programs, which many experts feel are critically important, particularly for substance-abusing pregnant women and those who have been abusing any kind of drugs for any period of time, is virtually impossible under the Medicaid program the way it's set up today and the way it's being administered.

Why is that? First of all, there is no explicit statutory mandate to cover substance abuse in the Medicaid Act. So, in order to cover it, you've got to fit the services into some other categories, such as in-patient hospital care, which is why hospital detox gets covered or out-patient clinic services, which is how you cover the methodone maintenance.

So it ends up being like trying to fit a square peg into a round hole. More importantly, there are three specific barriers to Medicaid. The first is called the institution for mental disease exclusion. The statute says that people under 65 who are in institutions for mental diseases are not eligible for Medicaid.

Well, what's that got to do with substance abuse? The Health Care Financing Administration has taken the position that substance abuse is, in fact, a mental disease. Therefore, if you are in a residential treatment program, the whole program could be excluded from Medicaid coverage as being considered an institution for mental disease.

I'd like to give you a short real-life example of how this actually happened to a facility in Minnesota called Granville House. This was a residential treatment facility for substance abusers. It sought Medicaid payments in 1980. It was denied on the grounds that it was an institution for mental disease.

The facility sued in federal court. In fact, the federal court agreed that the department's position or definition of the institution for mental disease was far too restrictive. That lawsuit was appealed by the department, and the case dragged on for five years, being twice in the federal District Court and twice in the 8th Circuit Court of Appeals and once before the department's own grant appeals board.

Each time the courts said the department's definition was too stringent and ordered the department to come up with a new definition. Finally, in 1986, the department did. However, I should note that this definition has not been published as regulations, so it's never been subject to public comment.

The new rules seem to follow the court decisions in saying that these treatment facilities are not automatically institutions for mental diseases. But then they added a catch. They said that if the treatment program provided treatment based on a psychiatric model, it would be considered an institution for mental disease and the people would be excluded from Medicaid coverage.

If they use an alcoholic's anonymous model, a narcotics anonymous model, and they use lay counsellors and peer support groups, then they would not be providing a medical service which would be compensable under Medicaid. So you're damned if you did and damned if you didn't. I mean, one way or the other, you were going to get excluded from Medicaid.

So, after five years of what appeared to be successful litigation against the Department of Health and Human Services, Granville House closed its doors because it could no longer financially continue without Medicaid reimbursement. As a result, those federal guidelines have never been challenged in court to my knowledge, and they continue to be on the books today.

I should point out that as part of OBRA '89, Congress mandated HHS to do a study on this institution for mental disease exclusion. HHS, I've heard, is moving forward and is supposed to be looking at the impact of this exclusion on drug treatment programs. A report is due to Congress in October of 1990, according to the Act.

The second barrier to Medicaid coverage is this medical model requirement, which I have already mentioned. If you're providing the AA type treatment using lay counselors, they will not consider it to be compensable under Medicaid.

The third barrier is that the department has taken the position they do not have the legal authority to cover room and board costs for residential treatment programs. They say that the Medicaid statute allows them to pay for capital costs only for hospitals, nursing homes and hospices because they are specified in the Act. As I said before, there is no mention of drug treatment in the Medicaid Act. So HCFA takes the position that they can't cover it.

Now, I'd like to discuss some approaches that have been taken and that can be taken to deal with these barriers. My home State of Pennsylvania took the approach of passing a state statute, Act 152, which was enacted in 1988, which provides a state funded Medicaid benefit to cover the entire continuum of drug treatment and alcohol treatment services, not just for pregnant women but for all Medicaid-eligible persons. That program is currently being phased in over a five-year period. It has been funded and we're moving ahead with that. A lot of people are very hopeful that it will go a long way to provide that sustainable funding base which is so needed. However, I have to point out that right now the state is really pulling the cart by itself.

They are not getting federal match for the money they are paying except on the hospital side and the methodone maintenance side. So, there are real serious problems that the state will face down the road as this program gets implemented without getting federal matching dollars.

A similar provision has been offered on the Senate side here by Senator Moynihan as an amendment to S–1711 that was accepted. But, as you know, that bill is still in conference committee and it doesn't look like it will be coming out. There were concerns about the cost of covering substance abuse treatment for all Medicaid-eligible persons.

I would like to point out, however, that these costs could be significantly reduced if Congress targeted the Medicaid coverage for pregnant women. The good news is that there is a provision already in the Medicaid Act which would make that targeting very simple.

The provision says that "states must provide to pregnant women coverages of services that are related to other conditions which may complicate pregnancy." I'm reading from the statute now. The important thing is that the states do not have to provide these services to all other Medicaid eligibles. These are services specifically for pregnant women.

It seems to me that Congress could fairly simply amend that provision of the Medicaid Act to clarify, number one, that substance abuse is a condition that complicates pregnancy—we certainly all know that—and specify that the full range of appropriate treatment services could be covered, notwithstanding this institution for mental disease exclusion. I think that needs to be dealt with and get that out of the way.

I think that it would also help to add a sentence in there that would state that room and board costs could be reimbursed so that the residential treatment programs could get their costs covered. Finally, Congress would also need to amend the current provision which limits the duration of covered services to the pregnancy and then for two to three months following the pregnancy.

Obviously, you would want to allow a woman who entered treatment while she was pregnant to complete her treatment even if that took more than two or three months after the birth of her child. The point is that these kinds of amendments could probably

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be done in three or four sentences. It would not be a very complex problem.

I would also like to mention that in terms of the cost, there was a study done by the Illinois Department of Alcoholism and Substance Abuse—by the way, I have recently learned that Illinois does have what they call a waiver in order to cover substance abuse treatment, the full range, under Medicaid. They have recently issued their regulations to cover that.

So, the state has done a study where they found that every dollar spent under Medicaid for substance abuse treatment resulted in almost $5.50 in savings on other health care costs. So, this is the kind of example where if you spend a little money, you can save a lot.

The other thing is that, as Dr. Halfon mentioned, you really do need to coordinate your Medicaid program with your other programs that are serving this population, like the MCH and your ADAMHA block grants set asides.

The bottom line is that this is a time of growing concern over the deficit in federal spending. We must be certain we are getting the most out of the money that we are spending. Right now, as far as Medicaid is concerned for substance-abusing pregnant women, we're not getting the most for our money. I believe that Congress has both the opportunity and the obligation to see that the Medicaid program meets the needs of the people it is supposed to serve and meets the expectations of the taxpayers that it be run in an effective manner.

Thank you very much.

[Prepared statement of David Gates follows:]

PREPARED STATEMENT OF DAVID GATES, J.D., STAFF ATTORNEY, NATIONAL HEALTH LAW PROGRAM, INC., WASHINGTON, DC

MEDICAID & MATERNAL ADDICTION: WHY IT DOESN'T WORK AND HOW TO FIX IT

I. What Medicaid Covers Now

Significant amounts, probably in the millions, are being spent each year under Medicaid on substance abusing pregnant women and their babies. However, very little of this money is being used for substance abuse treatment. Most of the Medicaid funds are going to neonatal intensive care units in hospitals to try to save the lives of babies after addiction has done its damage.

Medicaid funds that are going to treatment primarily pay for detoxification in hospitals or for methadone maintenance clinics. It should be noted that although detox often is a prerequisite for treatment, it is not itself treatment. Detox is not likely to help a substance abuser get off alcohol or drugs unless she is provided real treatment immediately following completion of detox. As for methadone maintenance, it is simply not appropriate for alcohol or cocaine addictions, which are the drugs of choice among women. Furthermore, while methadone may be a useful component in a broader treatment program for heroin addicts, the effectiveness of many existing methadone maintenance programs has been called into question by a recent GAO report.[1] The point is, while Medicaid funds are being spent to treat the effects of maternal addiction, very little is being spent to treat the causes.

Inpatient substance abuse treatment for pregnant women under 21 can be covered under Medicaid if provided in a psychiatric hospital.[2] However, treatment in these facilities tends to be very expensive and not geared specifically to substance abuse. Furthermore, psychiatric hospitals are unlikely to be able to provide the necessary prenatal care. Coverage is a state option.[3] Medicaid coverage of outpatient drug-free substance abuse treatment services is more problematic due to the absence of a clearly "medical" component to the treatment (discussed further below).

Residential treatment services provide the greatest challenge in terms of coverage under Medicaid. This is unfortunate because these programs are often less expensive and more specific to substance abuse than many inpatient hospital programs (which tend to primarily be psychiatric units) while many experts believe they are more effective, particularly for hard core drug abuse, than outpatient programs.

Most residential programs are not able to get Medicaid coverage as hospitals or psychiatric hospitals because they are not medical or psychiatric institutions and are therefor unable to get licensure or JCAH accreditation as a hospital or psychiatric hospital or meet the other Medicaid requirements for hospitals.[4]

Probably the most appropriate provision for Medicaid coverage of residential treatment programs is the so-called "rehab option".[5] The rehab option permits states to cover "rehabilitative services" which are defined as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."[6] While an initial reading of this provision might suggest it is aimed at physical, occupational and speech therapies, those services are explicitly covered under another provision.[7] Therefor, the rehab services covered under this provision must encompass some other services. Several states are using the rehab option to cover intensive community based mental health services such as partial hospitalization.[8] The full range of services that may be covered under the rehab option remains unclear.

II. Barriers to Medicaid Coverage

The IMD Exclusion

The Health Care Financing Administration ("HCFA") that administers the Medicaid program takes the position that substance abuse is a mental disease.[9] Since residential programs treat people with "mental diseases" (by HCFA's definition of that term), HCFA has found some of these programs to be institutions for mental diseases.[10] By finding a residential substance abuse treatment program to be an IMD, every person under the age of 65 who is residing in that program is excluded from Medicaid, not just for coverage of their substance abuse treatment but for any Medicaid covered service (including prenatal care) regardless of where it is provided.[11] Therefor, for residential substance abuse treatment programs and Medicaid-eligible clients residing in them, the definition of an IMD is critical.

The statute defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[12] Obviously, the easiest way for a residential treatment program to avoid being classified as an IMD is to have less than 16 beds. Unfortunately, since few free-standing residential programs were designed with Medicaid in mind (due to the difficulties in getting Medicaid coverage), many have 16 or more beds.

Prior to 1986, HCFA had focused primarily on the diagnoses of the people being treated by the facility. If the majority were diagnosed as substance abusers (which, as noted above, HCFA considers to be a mental illness) the facility was considered an IMD. However, two court challenges and an order from their own Grant Appeals Board forced HCFA to look instead at the nature of the treatment being provided.[13]

In 1986, HCFA issued new guidelines on IMDs.[14] While seeming to implement the Court and Appeals Board decisions that the type of treatment provided and the qualifications of the persons providing the treatment be the primary factors in determining IMD status, HCFA created a "catch 22" under which most residential substance abuse facilities continue to be excluded from Medicaid coverage. A facility that follows a psychiatric model using medically trained and licensed personnel is considered an IMD (thereby excluding from coverage at least for those patients between 21 and 65) while a facility that uses peer support and lay counselors would not fall into the IMD exclusion but its services would not "constitute 'medical or remedial treatment' required for Medicaid reimbursement under 42 CFR 440.2(b)."[15] Unfortunately, the plaintiff in the lead case that forced HCFA to revise its IMD standards was financially unable to continue its litigation and the 1986 standards remain unchallenged.[16]

While Congress has not dealt with the problems raised by the IMD exclusion in the context of residential substance abuse treatment programs, it has expressed its concern about the impact of the IMD exclusion on the provision of psychiatric and other mental health services. In OBRA '89, Congress required HCFA to study its policy regarding the IMD exclusion and the statutory exclusion itself and report to Congress by October 1, 1990 on any statutory or policy modifications that "may be appropriate to accommodate changes that may have occurred since 1972 in the delivery of psychiatric and other mental health services on an inpatient basis...."[17] As part of this mandated study and report, HCFA will examine the effect of its interpretation of the

IMD exclusion on Medicaid coverage of residential substance abuse treatment and will also consider the possibility of exempting these facilities from the IMD exclusion.

Medical Model

HCFA has indicated it will look at the nature of the treatment provided and at the training and qualifications of the people providing it to determine whether the treatment can be covered.[18] Where treatment "follows a psychiatric model and is performed by medically-trained and licensed personnel" HCFA will find the treatment to be medical in nature and therefor coverable under Medicaid.[19] However, where treatment is based "on peer counseling and meetings to promote group support and encouragement, and they use primarily lay persons as 'counselors'" HCFA will probably find that the treatment is not medical in nature and therefor not coverable under Medicaid. Most substance abuse treatment programs follow the latter model rather than the former. Treatment programs that do not use a psychiatric model are more likely to meet HCFA's "medical" requirement if they use licensed or certified substance abuse counselors (in states that have some licensure or certification requirements).

Room & Board Costs

HCFA's contends that absent explicit statutory authorization, the Medicaid program may not reimburse providers for room and board costs (which comprise a significant portion of the costs for residential programs).[20] Since the Medicaid Act only explicitly authorizes capital reimbursement for hospitals, skilled or intermediate care facilities (nursing homes) and hospices, under HCFA's view states may not reimburse non-hospital residential treatment programs for their room and board costs.

Some residential treatment programs have been able to get around this by operating in an unused section or wing of a general hospital.[21] Another approach some residential treatment programs have taken is to become licensed as intermediate care facilities (for which Medicaid can reimburse room and board costs).[22] The practicality of this approach depends in large measure on the licensure requirements of the state where the program is located.

This approach will become increasingly impractical as of October 1, 1990 when the statutory distinction between skilled and intermediate care facilities will be eliminated. These two categories of facilities will be replaced by a single category entitled "nursing facilities".[23] The practical effect of that elimination will be to require facilities that had been licensed as intermediate care to meet federal requirements that had previously only been imposed on skilled care facilities. One of the most difficult "nursing facility" requirements for substance abuse treatment programs to meet is the requirement that licensed nursing services (RN or LPN) be provided 24 hours a day and that an RN be available 8 hours a day, seven days a week although this requirement may be waived by the state under certain circumstances.[24]

Furthermore, even if a residential facility was able to comply with the nursing facility requirements, it might still not qualify as a nursing facility because the statute excludes facilities that are "primarily for the care and treatment of mental diseases" (HCFA considers substance abuse to be a mental disease) from coverage as nursing facilities.[25] However, states could still reimburse free-standing residential programs under Medicaid for the cost of providing counseling and other therapies and use their ADAMHA block grant funds or other funding streams to cover the room and board costs.

III. Removing the Barriers

Pennsylvania's Act 152

One state has gotten around the various barriers to Medicaid coverage that are set forth above by establishing a parallel Medicaid program for substance abuse treatment using only state dollars. In 1988, the Pennsylvania General Assembly enacted Act 152 which provides Medicaid coverage "for a continuum of alcohol and drug detoxification and rehabilitation services".[26] The act specifically covers non-hospital detox and residential treatment facilities. The act also requires the state Medicaid agency to consult with the state Alcohol and Drug Abuse Agency and for the two agencies to commission an independent evaluation of the success of treatment funded under Medicaid. In addition, Act 152 contains a provision requiring all licensed substance abuse treatment facilities to admit "at reasonable rates" people on Medicaid.[27] [Section 2335(a)] While the language is not clear, it was the intent of the parties who negotiated this language that "reasonable rates" refer to reimbursement rates. In order to reduce the initial cost of the act and to allow time to set up the necessary administrative structure, the act phased in Medicaid coverage over a five year program although the state Medicaid agency is aiming to implement the act state-wide more quickly. Of course a state may not overturn federal Medicaid law so the barriers to federal funding remain and funding for Act 152 coverage comes solely from the state so far. However, the state is exploring the possibility of getting federal financial participation, at least for some of the covered services.

"Conditions that complicate pregnancy"

While there are several provisions of the Medicaid Act which may be used generically to fund substance abuse treatment there is a provision specific to pregnant women. It requires states to cover pregnant women whose income does not exceed a level set by the state which must be at least 133% of the federal poverty level and no greater than 185%.[28]

Services covered for pregnant women who are Medicaid eligible under this provision are "services related to pregnancy...and to other conditions which may complicate pregnancy." [Emphasis added][29] Without question, substance abuse is a "condition which may complicate pregnancy". The Health Care Financing Administration ("HCFA") has made it clear that a state may cover services for pregnant women that they do not cover for other Medicaid eligibles.[30] Given the current fiscal restraints on the federal government and many states, targeting coverage of substance abuse treatment under Medicaid to pregnant women without having to cover all Medicaid eligibles may be particularly attractive.

There are however drawbacks to coverage under this provision. Pregnant women who are Medicaid eligible under this provision lose their eligibility 60 to 90 days after the last day of their pregnancy.[31] In many instances addicted mothers will need more than two months of treatment following the birth of their child, especially if they entered treatment late in their pregnancy. Mothers under 21 could have their continued treatment covered under EPSDT if they were sent for an EPSDT screening. For mothers 21 and older, states could cover the cost of treatment following the 60 day cutoff under another funding source such as the ADAMHA Block Grant although this would require coordination between two different state agencies. The "single state agency" for alcohol and drug abuse is usually a different agency than the single state Medicaid agency. Of course, Congress could eliminate this problem by exempting pregnant women in substance abuse treatment programs from the 60 day limit.

An even greater drawback to the effective use of Medicaid is HCFA's position that the coverage provisions regarding pregnant women do not supersede the IMD exclusion and HCFA's perceived lack of authority to pay room and board costs in a non-hospital residential setting. While these restrictions would not affect outpatient or hospital-based programs, they would limit a state's ability to use Medicaid to cover non-hospital residential treatment. Congress could eliminate this problem by exempting substance abuse treatment programs for pregnant women from the IMD exclusion.

David Gates
Staff Attorney

1.Report GAO/HRD-90-104

2.42 USC 1396d(a)(16). The term "psychiatric hospital" is defined at 42 USC 1396d(h) and 42 CFR 440.160

3.42 CFR 440.210

4.As to acute care hospitals: 42 CFR 440.10. As to psychiatric hospitals: 42 CFR 441.151 (JCAH accreditation), 42 USC 1396d(h), 1395x(f) and 42 CFR 440.160 and 441.156 (other requirements).

5.42 USC 1396d(a)(13)

6.42 CFR 440.130(d)

7.42 USC 1396d(a)(11) & 42 CFR 440.110

8.Koyanagi, *Operation Help, A Mental Health Advocate's Guide to Medicaid* (National Mental Health Assoc., 1988), pp.51-53.

9.State Medicaid Manual, Section 4390(D)(1) (9-86

10.*Granville House, Inc. v. HHS*, 772 F.2d 451 (8th Cir. 1985)

11.42 USC 1396d(a)(22)(B). If the program qualifies as a psychiatric hospital (which is unlikely), persons under 21 would not lose Medicaid eligibility. 42 CFR 441.13(a)(2)

12.42 USC 1396d(i). See also *Connecticut Department of Income Maintenance v. Heckler*, 471 US 524 (1985) holding that an intermediate care facility could be an IMD.

13.*Minnesota v. Heckler*, 718 F.2d 852, 863 (8th Cir. 1983); *In Re: Granville House, Inc*., Decision No.529 (4-9-84), Departmental Appeals Board, HHS; *Granville House, Inc. v. HHS*, 715 F.2d 1292 (8th Cir. 1983)

14.State Medicaid Manual, Transmittal No.20 (9-86)

15.Section 4390(D)(3), State Medicaid Manual (9-86)

16.Conversation on 5-7-90 with Jay Hartman, Esq., counsel for plaintiff in *Granville House*.

17.Section 6408(a)(2)(A) of P.L. 101-239

18.Section 4390(D)(3), State Medicaid Manual (9-86)

19.Id.

20.Letter dated June 23, 1987 from William Roper, then Administrator of HCFA, to the Director of the Illinois Department of Public Aid

21.Conversation with Sam Muszynski, Jr., General Counsel to the National Association of Addiction Treatment Providers, on 2-21-90

22.Granville House Inc. v. HHS, 715 F.2d 1292, 1304 (8th Cir. 1983)

23.Section 4211(h) of P.L. 100-203 (OBRA '87), effective 10-1-90

24.42 USC 1396r(b)(4)(C), effective 10-1-90

25.42 USC 1396r(a)(1)

26.71 P.S. 611.14(a)

27.Section 2335(a) of the Act

28.42 USC 1396a(a)(10)(A)(i)(IV) and 1396a(l)(2)(A)(i)

29.42 USC 1396a(a)(10)(E)(VII)

30.Section 4421(B)(3) of the State Medicaid Manual (7-88)

31.The statute states that a pregnant woman is eligible "through the end of the month in which the 60 day period (beginning on the last day of her pregnancy) ends." 42 USC 1396a(e)(5)

STATEMENT OF ROBERT WOODSON, SR., PRESIDENT, NATIONAL CENTER FOR NEIGHBORHOOD ENTERPRISE, WASHINGTON, DC

Mr. WOODSON. Thank you, Congressman Miller. My name is Robert L. Woodson, Sr., president and the founder of the National Center for Neighborhood Enterprise, an organization I founded nine years ago, dedicated to assisting low-income people to achieve independence and self-sufficiency.

Previous to that, I've worked several years as a trained social worker, as a correctional officer in a juvenile jail, seven years in the child welfare system and as a psychiatric social worker. For the past 20 years, I've directed many national and local programs to improve the lot of poor people.

So I approach this problem from the perspective of a practitioner from inside the services system but also someone who stepped outside of the social system and began to work directly with people affected by the problems. Let me commend some information to your attention.

My testimony will depart from those of my colleagues on this panel because I do not believe that the problems that we confront today are a crisis in programs or a crisis in budgets. The facts are that in 1960, only 2.5 percent of black children born were being raised in households where the mother was never married. In 1980, that number has increased to 62 percent.

Prior to 1960, 78 percent of black families were whole, man and a women in them; today only 40 percent. Precisely, during this period of time, we have expended over $1 trillion in programs of aid to the poor. Twenty-five years ago seventy cents of every dollar went to the poor. Today, 70 cents of every dollar goes to the industry that serves poor people.

What this has meant is that—we have looked at why, in the face of these huge expenditures, have we witnessed a tremendous decline in the functioning of families, black families in particular? I'm not suggesting that there is a direct correlation but it is interesting to observe that as we seek new solutions, we must find answers to these questions as to why.

Congress is constantly bombarded with the problem with we're not spending enough. So we looked into these communities. There are a few studies done to determine where poor people turn in times of crisis and trouble. What kind of solutions do they seek themselves? There were two studies that I'm aware of by Don and Rachel Warren of Oakland University of Michigan that went into low-income communities and asked the poor themselves, what do they consider a valid, trusting resource?

They found that in orders of importance to them, that low-income people selected institutions that were indigenous to their community—up to about 80 percent of them did. In order of importance to them, the first seven institutions that they chose were families, friends, ethnic subgroups, voluntary associations, their local church. The eighth institution that they selected was a professional service provider.

Yet, in light of this reality, we tend to deliver services to the institution of last choice of those in need and wonder why we fail to arrive at a solution to the problem. So, what we have done as an organization, and I have over the years, is spent the bulk of our time working within low-income communities to try to determine what is it that these institutions are doing and what impact can they have on public policy?

We have found, following the medical model that was referred to and the principles that drives the National Center, that the most effective form of treatment of the human body is that form of treatment which is least intrusive, that which strengthens the body's own immune system to heal itself. We know that the most expensive and the most devastating form of treatment is a transplant.

So we believe that the institutions that are indigenous in the community are antibodies within the community and that they have tremendous healing properties. You have an example of those in Detroit with Reverend Lee Earl and some others in those communities that have demonstrated a tremendous capacity to heal.

The problem is that the resources that are so needed by these local organizations are seldom available to them because they do not qualify for the various federal grant programs that are available. Many of them don't have word processors or grant writers and what have you. Yet, they are doing a most effective job.

So what we have done at the National Center in the whole drug area is that we canvassed about 1500 community-based programs where the leadership of those programs shared the same zip code of those experiencing the problems.

As a consequence of this canvass, we sent out a staff to visit 50 of the most promising of these. Reverend Lee Earl of Detroit was one of those that we selected to highlight on a teleconference where, for five hours, we broadcast to about 13 different locations for five hours examples of what community-based efforts could do to eradicate this problem and address the needs of these drug-addicted mothers and children that are in crisis.

This has had a tremendous impact in terms of making people aware of this resource. Yet, when we look at the various drug intervention programs, we find that those local organizations do not qualify for support. They do not because they are informal. They do not have a lot of trained professional staff, but they are effective.

If you saw "60 Minutes" this past Sunday, Bertha Gilky, one of the people that we trained, with Secretary Kemp. These folks have demonstrated that they can come in and dramatically change the lives of people, particularly young girls who are faced with the problems of drug addiction.

So, what we must do, it seems to me, is find—there are several things that I believe we must do in order to take advantage of these natural healing agents within communities. The first thing, it seems to me, we need to undertake some studies of why 50 percent of families that are indigenous to these communities are able to raise daughters who are not having babies, that are not on drugs and they are not dropping out of school.

We need to find out why certain families in low-income communities are capable of achieving against the odds and what explains their success. How could a woman abandoned by her husband at age 19 with 5 children to public housing and welfare manage to get off welfare in 3 years and send all 5 of her children to college and make it possible in a seven year period for 680 other youngsters indigenous to that community to go on to college. Researchers have never come down to those communities to study why they were successful.

We also must identify those young women in communities that have not become pregnant and bring them before panels like this to ask them how they were able to resist what their peers have not in order to build on strengths. It seems to me that you can learn very little by studying theory except how to create it.

What we must begin to do among low-income people is study those elements within those communities that are successful to ascertain how did they achieve. At our teleconference, we had about 40 young people in groups of 6 around the country that were living in drug-infested communities. In some cases, their sisters or brothers were drug infested but they were not—in order to ask them why and how they were able to achieve without taking drugs.

It seems to me that there's an awful lot that we can do. Another recommendation that I would make is, we worked for about four years with the Office of Juvenile Justice and Delinquency Prevention on a very interesting experiment as to how the federal government could insinuate money into these communities without these local and formal organizations having to go through the bureaucratic hoops that it normally takes to receive a grant.

We worked for about four years with the Office of Juvenile Justice and a small grant program where the National Center received some grant funds, the bulk of which went out to local neighborhood organizations. The criteria was, they had to have budgets under $150,000. They could not qualify for United Way dollars.

The leadership had to be indigenous to the community. They had to have a record of performance before funding was available. They had to demonstrate that they have successfully addressed the problem for which they were applying for support. As a consequence, we were able to, through our networks, distribute very simple application forms that could be filled out, three pages. It could be filled out handwritten. The groups received funds from $500 up to $10,000. They would get a response within 90 days.

As a consequence, we were able to reach quite a few groups. This program was evaluated by Northwestern University, School of Urban Affairs, and found that this method of reaching groups was a tremendous success and where the local neighborhood groups were able to generate $3.00 for every one that was expended.

They didn't have to go through—no one ran away with the money. They were able to demonstrate that they can have a dramatic impact on some of these efforts.

Let me conclude my testimony by giving you an example of what happens with the tension between traditional service providers and indigenous service providers in the competition for funds and also in competition for recognition of what they do.

In Brooklyn, New York, there is a community-based effort called Sisterhood of Single Black Mothers, started 18 years ago before teen pregnancy was fashionable, by a woman who was a teen mother herself, Daphne Busby. She reached out to local young ladies who were pregnant and took them in. After that first child, she formed a community, a family of these youngsters and used the peer pressure to reach out to younger women to deter them from becoming pregnant, began to babysit one another and set up motivation programs.

They were able to reach out to the fathers of these young babies and reach out to their families as a means of deterring—getting them involved. Yet, they were struggling for many, many years. Their influence expanded. On the weekends, since youngsters like to have parties and enjoy themselves but often have to pay for them in the coin of sex and drug abuse, they had parties that were supervised by parents in their community.

Now, what happened is when professional program providers came to help Daphne and sat with her for two weeks, they recorded everything she did, received a grant of $235,000 from a foundation, tried to replicate what she did, only reached 35 girls in one year.

A researcher came in to evaluate the program, found that what they had done was not justified and the funds were withdrawn. As a consequence, when Daphne came in for funding, they said the approach that you are taking doesn't work. As a consequence, she was not able to expand her program, but it continues.

I say that to say that we must begin to examine the nature of the institutional approaches we are taking to intervene in low-income communities and begin to look for the strengths that exist there. There need to be more field hearings because the folks that I'm talking about cannot afford the freight of coming to Washington to testify at hearings like this.

I commend this committee for going to Detroit and having people like Reverend Lee Earl, but he is only one of thousands of community resources that are out there available to participate in the struggle if we can make more constructive use of what they do.

Thank you.

[Prepared statement of Robert Woodson, Sr., follows:]

PREPARED STATEMENT OF ROBERT L. WOODSON, PRESIDENT, NATIONAL CENTER FOR NEIGHBORHOOD ENTERPRISE, WASHINGTON, DC

Mr. Chairman and members of the Select Committee:

I am Robert L. Woodson, president of the National Center for Neighborhood Enterprise (NCNE), a research and demonstration organization that, for the past decade, has advocated self-help strategies as a way of addressing problems in low-income communities. This is the perspective from which I will be giving my testimony. NCNE has worked with, and assisted hundreds of grassroots organizations throughout this country in their fight against drugs and drug related crime. We do not operate or fund any specific programs, rather we document and provide technical assistance to grassroots organizations who are on the front lines in the War on Drugs. We use the information gathered from our direct involvement with low-income Americans to educate both the general public and the public policy community on the merits of grassroots community oriented strategies. Recently, NCNE, along with the Office of Juvenile Justice, sponsored a national satellite teleconference to highlight grassroots organizations who are winning the war on drugs. The teleconference was broadcast to hundreds of communities across this country and Canada, to give them hope and information on how to win their war on drugs.

The 1980's was the decade of the much heralded "War on Drugs." The obvious victims of this war are the fallen men and women who protect our communities as well as the perpetrators of drug-related crime. Not so obvious are the innocent children who bear the emotional and physical scars of families torn apart by drug abuse. As we move into the nineties, this war is still being fought on all sides--including law enforcement, education and treatment for addicts. While most of these strategies emphasize the use of professional service providers, the one crucial element that has been left out of this overall strategy is the people who live in the affected communities.

We are all aware of the merits of educating the public on the hazards of drug use. This approach been primarily effective in middle class communities, but the results in low-income communities have been mediocre at best. Out of frustration we have turned to law enforcement to quell the violence. This approach has also had mixed results in low-income communities and has done nothing to address the phenomenon of drug addicted parents and their children. The plight of drug torn families has led to the current cry for more treatment centers and social service intervention. However, research has indicated that treatment centers have a high rate of failure because the patient is returned to the environment where the problems began.

For the past 25 years the Federal government has experimented with social service intervention strategies to address the problems of low-income people. We have expended over one trillion dollars during this time and yet we are told that we have roughly the same number of poor people as we did when these programs began. We are also told that more children are dropping out of school, teenagers are still having babies, and a record number of children are being subjected to the perils of the foster care system. To state that grassroots leaders are skeptical of more traditional government intervention would be understating their position at best. According to the study, "Helping Networks: How people cope with problems in the metropolitan community" researchers Don and Rachel Warren of Oakland University in Michigan, found that professional service providers are the last resort low-income people turn to in times of crisis. Over 80 percent turn to institutions within their own communities. Yet, it is professional service providers that looked to first by lawmakers when attempting to address problems affecting low-income communities.

Even if there were a sufficient number of programs and a sufficient amount of money to operate them, there is evidence to suggest that few would participate. A case in point is the Women, Infants and Children (WIC) program in Washington, D.C. Washington D.C. can boast that it has the most comprehensive and accessible WIC program in the country. WIC services are virtually free to anyone who earns less than $20,000 and there is an aggressive outreach program to assure that women know of its services and availability. Still, Washington, D.C. has the highest infant mortality rate in the country (27 per 1,000 in 1989). It is time that we examine the instruments of salvation to reveal, if in fact, they are sowing the seeds of destruction.

This committee has heard grassroots leaders, such as, the Rev. Lee Earl in Detroit and his program Reach, Inc. The Committee could have held hearings in south central Los Angeles, home of the infamous "Crips and Bloods" gang wars that claim over 400 lives every year, and heard from Mr. Leon Watkins. Mr. Watkins, an ex-addict himself, was able to quell gang violence in his neighborhood and organize a one day city wide moratorium on gang violence. He operates his program without the benefit of Federal or State money. The committee could have held its hearing in the Liberty City section of Miami, Florida and heard from Ms. Dorothy Perry. Ms. Perry takes children into her home, many of whom come from drug torn families in her public housing development, and provides them with love, discipline, bible study programs, field trips and most of all a safe haven. At any one time, Ms. Perry will have 40 children in her house and many will spend the night. She has accomplished this despite being served with eviction notices from the local Housing Authority and threats from area drug dealers. Her program receives no public funding.

NCNE has been able to identify hundreds of organizations who are achieving similar results. The documented characteristics that bond them together include:

- A tremendous emphasis on personal responsibility.
- The leaders of the organization live in the affected community, which makes them accountable to their clients.

- The organization is located in the affected community.
- A complete knowledge of the community and its residents.
- The flexibility that allows a program to respond to change.
- Small staffs allow for personal interaction.

You would be hard pressed to find these features in government designed programs.

The most pressing aspect of the drug epidemic is the plight of children born addicted to drugs and children neglected by their drug addicted parents. One community response to this problem has been informal adoption or utilizing the "extended family" network. Many will seek this type of arrangement because the foster care and adoption systems are too bureaucratic and do not serve the immediate needs of the child. In November of 1989, NCNE convened a conference consisting primarily of women who have informally adopted children and found that the crack epidemic has dramatically increased the number of children in need of care. Black families, particularly those made up of single women, have risen to the challenge by opening their homes to these Drug War refugees. However, there has also been a price to pay. One care provider related a story of another woman in her community who has cared for a baby born addicted to crack. The baby was in need of an operation, but as is often the case, the mother could not be found. The woman took the baby to the hospital and the child was given the operation. The woman is now saddled with $35,000 in medical bills, because she is not recognized as the legal guardian of the child, even though she has cared for the child since birth. Supporting these individuals will keep an over-burdened child welfare system from experiencing further chaos and would greatly enhance the lives of these children as well as the community's capacity to solve this problem.

Other recommendations are as follows:

- Establish guidelines that would allow states to terminate the parental rights of a mother or father if, after giving birth, the parents make no arrangements for the care of the child within a six month period. The child should then be placed for adoption. Currently, many "boarder babies" languish in hospitals for a year or more.
- Give priority to "Boarder babies" in adoption placement and placement authority should be given to licensed community based adoption centers.
- Include the involvement of the local grassroots

leadership in the formation and implementation of any drug treatment programs targeted to addicted mothers.

- Develop mechanisms that would enable anti-drug money to get to grassroots community organizations. Currently, many groups who are engaging affective activities cannot afford to apply for federal money.

- Extend monetary benefits to families who care for children on a continuous basis of not less than 30 consecutive days. A taskforce should be established to design ways to recognize informal care providers, both temporary and long term, so that these families may receive services only open to foster care providers.

Chairman Miller. Thank you. Mr. Woodson, in fact, didn't Daphne get a federal grant?

Mr. Woodson. She eventually got a federal grant, but I'm talking about early—I worked with Daphne very early on. For years and years, she struggled, working out of her home. Her phone was disconnected many times. There were a lot of starts and stops. A few of the people I'm talking about do, in fact, receive federal grants, but very few of them. That's my point.

Chairman Miller. Well, I find it's interesting anecdotal information. I find it interesting that you were saying this eight years ago. We've had an administration that keeps saying they wanted to look at successes. For eight years, we were supposed to be looking at successes.

This committee has probably 50 percent of its time been looking at successes, children that succeed, families that succeed, programs that succeed. Yet, I don't see the fact that they've responded. I don't understand this. This has been a hue and cry of people who didn't like governmental programs, keep saying why don't we look at children who didn't have babies and so forth. The fact is, we didn't even see any effort to do what you want to do.

Mr. Woodson. I agree.

Chairman Miller. I'm at a loss that after a decade, you're still here beating the war drum for essentially a program of people who were sympathetic who never did a damn thing about it.

Mr. Woodson. Well, as far as I'm concerned, Mr. Miller, there has not been very much sympathetic support for this from either Democrats or Republicans. There is still a fascination with this notion that only credentialed providers are the only legitimate agents of service to poor people. That's shared by Republicans and Democrats.

Chairman Miller. I guess I see it differently than you because I think that the question, certainly for this committee and for many of our colleagues, has been the quest for successful providers, whatever their background.

The question is, are they having success at mitigation or eradication of the problems that have concerned this committee. So I guess I just don't see it in the same light as you do.

Let me ask Mr. Gates. You're quite correct. Some of these amendments are only a couple of words or a couple of sentences, but the implications in terms of dollars are rather substantial in terms of the eligibility. I don't disagree with you, but essentially what you're saying is that women in danger of complications of pregnancies, if it's as you describe it, would be eligible for the match; right? The states would be eligible to provide services and receive a Medicaid match for the provision of those services.

Mr. Gates. That's correct. Yes, Mr. Chairman.

Chairman Miller. So, what we're talking about here is the sustained availability of funding?

Mr. Gates. That's right.

Chairman Miller. Neal, let me ask you, you mentioned the population at risk. I wonder if you just might expand on that a little bit because I think it's something that concerns the committee; you can add up sort of all the statistics and the question is, what's the real population that you're dealing here with?

In some instances, you're talking about people that have multiple risks. You're talking about people who repeat through the process. What is the real universe here that is circulating through and needs attention?

Dr. HALFON. I think we don't have a real good handle on that. You know, the estimate of the 370,000 babies born in hospitals around the country in the last year is one estimate that has been made of the number of children being exposed. I think that we really don't know on a population basis which women are receiving care, which ones are not, which ones are getting into programs, which ones do not.

We know there are very, very, very few programs available. We get statistics from a variety of cities of the number of women being turned away, but we don't have a really good sense of what the magnitude of the problem is both in the inner city areas and, as Senator Wilson suggested, in rural areas like Fresno.

Quite a bit more effort needs to be applied from the federal side in order to further define the problem. I am not just calling for more money for more research in some sort of blanket way, but I think that we really need to define the problem a lot more clearly.

Chairman MILLER. Well, I don't know if this is related, but in my discussions with some people in Seattle this last week—and they deliver most of what would be addicted children for the city in their facilities—they claim that they kind of lose half of this population as they walk out the door.

They don't know what happens either to that child in terms of any kind of health followup and/or the mother in terms of any—they simply lose, of the 400 a year, 200 of them almost immediately. The notion that they'll come back in for their services, they said there is just no management to determine whether we're seeing new people, the same person down the road. I don't know if that's related.

Dr. HALFON. Yes, we're seeing the same thing throughout California. It varies from county to county, hospital to hospital. If there is a good hospital protocol for assessing risk in women; perform the drug testing when it's indicated and then having the proper case management services available to track women once they leave, to link them up with services, you're obviously going to have better results.

Unfortunately, those kinds of basic services are not available or covered in many hospitals. Even if they have a social worker at the hospital or child protective worker at the hospital it is difficult to link the women with services. In most communities the services aren't there.

This is the reason why many women walk out of the hospital. If they stay in the hospital, they're not going to get services. However, if they leave, there's no where for them to go in the community in most cases. I think we could be doing a huge amount to alleviate this problem.

I think Mr. Gates suggestion to augment Medicaid would allow for payment of case management within the hospital and would allow us to track mothers more easily.

Chairman MILLER. Essentially, between your testimony and Mr. Gates and, I guess, other testimony that we've listened to, essentially it would seem to me that the financing at this point almost dictates that you not provide services in the hospital for this because someone is going to get stuck with the cost.

So, if you enter into the program, either you won't be able to continue those services—so, there's a break in the service here and that person or their social worker or someone else has to seek out now a program in the community that is funded in such a fashion so that they then can receive that individual.

In Detroit, we saw the connection between the hospital and the residential care facility and the ability to move people from one to the other on a rather limited basis. We've seen that in other instances where you start at the hospital and move people through or you start at a prenatal clinic and move people through. They exist in the country, but they are very limited.

It seems to me that the ordinary model is, the person checks themselves out of the hospital and eventually we run around and look for that person, either because we see the child now eligible through child protective services or foster care placements or something like that. Then we gather that person back in. It may be months. It may be weeks or whatever.

We again start trying to figure out how do we get reimbursed for the provision of services that this mother and/or child needs. I mean, that's kind of what's going on out there.

Dr. HALFON. The current system is very fragmented and it's very dislocated. There are certain glue services that case management could provide in a cost-effective manner. I keep coming back to this notion of case management, which is something that Medicaid can cover.

Congress says states may cover this but most states don't cover it. Having a case manager paid by Medicaid in a hospital would help connect the child and mother up with the EPSDT program that could continue to follow both mom and child after pregnancy, thus ensuring the acquisition of developmental preventive services.

It means that these little pieces have to be put together. They're not currently defined well in the federal legislation. What Mr. Gates was pointing out is that there are major gaps.

The Title XIX with the EPSDT program could be providing all the missing pieces. My own feeling is that the kind of amendments that are needed are not amendments that say that states may provide service; it's the amendments that say that states shall provide these services the same way that you've said that states shall provide prenatal care to women up to 133 percent of the poverty level and for kids up to 6 years of age.

Chairman MILLER. Ms. Smith, let me ask you a question. Senator Wilson and I were talking back and forth about the kind of model that you put here in terms of services versus punishment. I don't quite know how this debate is evolving at the moment, but I guess I'm kind of struck by the fact that, for whatever reasons, the women that have entered prison—which I assume for the most part is under a punishment model because you indicate a number of them are there now also because of people looking at their addiction—even where we now have a person in custody in a residential treatment, if you will, identified as a substance user, abuser, possibly pregnant, we're still not providing services.

Ms. SMITH. You're absolutely right. There are no services that are provided. In fact, just because at this point prisons are—what we're doing is we're locking up more and more people. What's happening is prisons are not dealing with rehabilitation either in the sense of deterring future criminal behavior or dealing with prisoner's needs.

They are dealing with warehousing folks. Just the notion that they will be able to provide the kind of comprehensive services that are needed to deal with the problems of pregnant alcohol and drug dependent women and their children is not——

Chairman MILLER. I'll have to get this information for the record, but my understanding from my colleagues on the Judiciary Committee is that the Department of Justice has just gone through a rather lengthy evaluation of a very successful program in terms of drug treatment in prison settings that has indicated that these people who have gone through the process in that setting, in fact may be some of the more successful people after their release that we have seen in a long, long time, but even that now apparently is being curtailed.

Apparently there is some experience to suggest that intensive work with these people while in prison is offering some success in terms of their avoidance of drug use afterwards and, in fact, even their avoidance of any illegal behavior after release.

Are you aware of that or do you know?

Ms. SMITH. I'm aware of it and I think that that's true, but I also think that comprehensive, good drug treatment can work in a number of settings.

Chairman MILLER. I understand that.

Ms. SMITH. Yes, I am aware of that. I think that you're right that those programs are being curtailed. In fact, the only one that I know of—not the only one but one that I know of that is very successful is in the women's prison in Framingham.

It's a very good program but, as we've all talked about, it's a program that's comprehensive. It has a lot of other things besides drug treatment, but there isn't really that kind of emphasis being placed on programs.

Chairman MILLER. Thank you. Mr. Walsh?

Mr. WALSH. Thank you, Mr. Chairman. I'd like to just ask Mr. Woodson a couple questions. You made some statements about statistics and the changes in society that have occurred since the 1960s and the amount of money that has been spent to deal with that and the fact that we have more impoverished people in the country today than we did then. Things seem to be getting worse and not better.

I'd like to ask you a number of questions, but why? Why is that?

Mr. WOODSON. Well, no one can say with certainty, but there are a number of reasons I think. For one, with the dawn of the 60s, there was an undermining of the indigenous institutions that helped define the values of people in those communities.

So I know, as someone who lived through that period active in the Civil Rights Movement, that when poverty programs came along and they came to New York City, for instance, it was Kenneth Clark, certainly no conservative, who called them welfare colonialism because people who were not indigenous to their communities in New York was defining what was important to Harlem, designing solutions that were going to be applied to Harlem.

It was only because of Kenneth Clark's challenge to that that the IRU Act and programs in New York that funded in that community. What they also did was during the first six months or so of the poverty era, the people involved were truly indigenous to the community.

When the OEO began to impose regulations like, to the community outreach workers, you had to have a bachelor's degree. Immediately, it changed the nature of the program so that offices were set up and run by people nonindigenous to the community. So people began to abandon their churches. Then we kept looking through professional—there was an undermining of the people, the institutions within those communities as well.

I think that there was a great emphasis on pathology that if a person was—in order to be eligible for a program, you had to exhibit some pathology. If you were pregnant, there was a program. If you were delinquent, there was a program. If you were an alcoholic, there was a program, on and on and on.

If you were like the two 14-year-old girls that we talked with six months ago here in the District, they are both 14 years old. Both parents are addicted. The mother is addicted to drugs. They called the coke hotline and asked for help for their mother and themselves. When X asked about what they are going through, one an expected pregnancy, what not—these girls are A students in their junior high school.

So, the question is, what is available for them so that they don't fall into that? So I think the whole complex of what we have done certainly has undermined the integrity of the communities.

Mr. WALSH. We hear the argument from time to time that government really has a mindset. We need to control the programs. We, the legislators, need to be the persons that dole out the money to make the people distributing those services at the local level happy.

The service providers are happy. The service receivers are not. Would you agree with that statement?

Mr. WOODSON. When people advocate self-help the way I do and with my experience, there is always this attempt to paint you as being bipolar. If you're for self-help, then you're against government. My position is that there are certain—when people are in distress, government has a responsibility and a role to play.

The question is, how does government execute that responsibility? I'm saying that perhaps what we ought to do is use agents that are indigenous to that community. Yes, the kind of requirements that are imposed that a company grants often makes the innovation that is employed by the local grassroots groups illegitimate.

In other words, if a program is designed with five goals in mind and it receives funds to accomplish these five things, but six months into the implementation they find that there are three other opportunities that they did not anticipate and they begin to pursue those, they are going to be evaluated based upon what they said they were going to do initially.

I've seen, often, groups that receive funds that are undermined. So that's what happens. The providers of service asks not which problems are solvable but which problems are fundable. They are not responsive or responsible to the people they serve. They are going to get funded whether or not they have demonstrated that they have any effect on solving the problem or not.

Mr. WALSH. It's interesting the statement that you made, if I could paraphrase it, "the more of a problem we have the more money we have to deal with that problem." As long as the problem grows, there will be money for the problem. If the problem shrinks, perhaps the converse is true.

I came from local government before I came here. I think everyone in government has a fear of failure, a fear that if we try to change the system, that whoever idea that is, they are going to get it back in their face when that fails because as soon as you try to change things, everyone is looking over your shoulder and they are just waiting for that idea to fail.

I've seen that. I've seen that here and I've seen it at the local level. That's just a comment, an editorial comment of mine because I've been there at the local level and here now. I don't see any different attitude at either level.

One of the things that we used to go through in Syracuse in our community development block program was the city administration would have a plan and then they would bring it out to the neighborhoods to run it by the neighborhoods. The people who were dependent upon that program would come out and advocate for it.

The people who were involved in quasi-governmental housing organizations and social services agencies, a lot of that was good. When you had a group who did not fit within the quasistructure of government or quasigovernment, they were kind of outcasts. Their role was to criticize the process.

When they brought forward ideas that didn't fit, they were kind of shuddered aside. It was very difficult for them to get any funding because they seemed to attack the structure as opposed to the—want to get involved with it and not be coopted by the process.

Those organizations were more involved with housing than with social problems such as health and drug dependency and so on. Is there any room, do you think, or any idea that you would have within present structure to bring people into the process who feel strongly about your sort of approach but can't get in now.

Is there any way to advocate for this other than before a hearing that really has no legislative responsibility?

Mr. WOODSON. Well, we're witnessing that right now. Again, I refer to the kind of work being done by Secretary Kemp at Housing and Urban Development. We started five years ago with five public housing developments where the residents had taken over and dramatically kicked the drug pushers out and dramatically changed those developments around.

We provided training to groups from around the nation. Through our teleconference we were able to reach other public housing developments throughout the nation. Now I have over 100 in training. Sixty-four of them are now resident managed and, with some dramatic results, a "60 Minutes" piece on Sunday demonstrated what can happen when you put the people in control who have a vested interest in solving the problem.

One of the ways to really distill this argument into a very simple debate, a very simple test is if the goal is to help 100 mothers who are at risk remain drug free and have healthy babies, then I would love an opportunity over a three-year period to select 100 of these mothers, allow our grassroots people with their own unique solutions address their needs and then let the traditional service industry select 100 women and do the same.

At the end of three years, let us measure the objective results. Were the intended interventions successful or not, not how many people were served, whether they got a WIC or WAC or what have you, all these other acronyms, but whether or not there was a decline in the number of children born drug addicted.

I contend that the only reason that grassroots groups continue to be effective is because they have to stand a measure of the marketplace in which they live in order for them to continue to enjoy support. I really think, Congressman, that that's the kind of—with the crisis that we face, we cannot turn our backs on a promising approach just because it is unpopular or unknown or because the people there are unfamiliar to us.

Mrs. BOGGS. Thank you very much, Mr. Chairman, and thank all of you. First, I would like to complement Ms. Smith. I've always been in great admiration of the National Women's Law Center and even more because of your work in a sadly neglected area. I thank all of you for your interest and for your participation.

I was especially grateful to be able to have the very specific suggestions for legislative corrections and approaches that you were able to give us. Mr. Gates, I really do thank you very much for that.

Mr. Woodson, I, too, have worked in the vineyards of neighborhood operations. During the 60s, to which you refer, I was on the board of Family and Child Services here in Washington where we had 44 agencies under our umbrella. I also was the volunteer chairman who helped to start the Head Start program.

I find your testimony very compelling. I think that whenever you get into governmental bureaucracy, you're going to find the setting of standards and the narrowing of focus, put onto the various programs. As you mentioned, in the beginning of the war on poverty programs, we really did reach out to the neighborhood areas.

As a matter of fact, many of the programs that we had were trying to abscrb the great influx of people from the south into Washington, it was difficult.

It was a tremendous problem to come into an area where there are no jobs for the unskilled. All of the neighborhood groups worked very hard.

We had a congressional wives' circle for Friendship House, which is a house right in the shadow of the Capitol. One year we turned our attention to raising enough money to do a neighborhood survey because we felt that the house was not really serving the neighborhood as it existed at that time.

That survey was taken on by the antipoverty program later to be a neighborhood survey program. I'm sorry it didn't work as well as you and I anticipated it would. I think the Head Start program has succeeded because it has remained a family-oriented, neighborhood-oriented program with tremendous involvement from the parents and neighborhood people.

I'm just very hopeful that we can recognize, as you have suggested, that we go back to making certain that old time neighborhood groups and now new interested young people can be employed in this most poignant sort of situation of mothers and pregnant women and their children addicted to alcohol and other drugs.

I really commend you for your work and your suggestions. I do hope that we will be able to follow some of them.

Mr. Woodson. Thank you.

Mrs. Boggs. Thank you. Thank you, Mr. Chairman.

Mr. Hastert. Thank you, Mr. Chairman. Mr. Gates, despite the hoops that you described to get Medicaid to pay for drug treatment programs, isn't really the bottom line that Medicaid can and, in most cases, does pay for drug treatment?

Mr. Gates. No. I'm afraid, Congressman, I would have to disagree. It does not. It pays for hospital detox. It pays for methadone maintenance clinics. To some extent, it will pay for some outpatient treatment. It's virtually unavailable for residential rehab services.

Mr. Hastert. That line item that, I think, it pays for is about $120 million. Have you ever estimated the cost for what it would cost if it were residential?

Mr. Gates. I'm sorry?

Mr. Hastert. The line item that we spend in Medicaid for drug treatment of various types is about $120 million. You wouldn't have any estimate of what it would cost if you went to residential as well?

Mr. Gates. If it were for residential as well? No, I did a real rough estimate what it would cost to cover pregnant women for the full range.

Mr. Hastert. Which was?

Mr. Gates. Which was $96 million, based on a CBO estimate for Senator Moynihan.

Mr. Hastert. How many states have refused to use Medicaid funds for alcohol and drug treatment; do you know?

Mr. Gates. Have refused?

Mr. Hastert. Refused?

Mr. Gates. Well, it's not so much the states refusing; it's more the federal government not giving the states the federal match. I only know of two states so far to my knowledge that do provide the full continuum, Illinois and Pennsylvania. I've heard that Washington is starting some pilot programs.

However, there is a group of organizations, many of whom are represented here today, who have done a survey of 10 states and we're going to be reviewing that probably tomorrow. We could get back to the committee with our results of that.

Mr. Hastert. That would be helpful. Mr. Woodson, I share your frustration on dealing with bureaucracy. We have had a dialogue over the last 10 years to 20 years. It seems that sometimes the bureaucracy is entrenched no matter what political party is in power and that bureaucracy is sometimes all powerful. It's awfully hard to curtail its power.

My experience in the Illinois General Assembly was that when we put the Child Abuse Prevention Act together to provide funds for new programs, all of a sudden, the bureaucracy channeled those funds in other directions. So I share your frustration.

It seems that the REACH program that we heard about in Detroit is one of the successes that you describe. What's the key in your view to linking federal funds to the community level? What do you have to do to get under, around or through that bureaucracy to make the things work at home?

Mr. WOODSON. I think that this is a frustration, I know—let me just say before answering the question—that's shared by Congressman Riegle too who said with the new drug monies coming down, the hustlers are coming out of the woodwork without demonstrating any ability and that in the meeting with him, he's interested.

I think that looking at the model that we employed in working with the Office of Juvenile Justice and Delinquency Prevention certainly is one where our support is given to an organization with the understanding that the bulk of those funds would be passed through to local organizations and a process in place that would set up standards that would only allow those organizations to compete with one another and not the larger traditional agency.

For instance, the guidelines that we set that the leadership had to share the same zip code with those experiencing the problems certainly eliminated a lot of folks who would otherwise just come in for the money. The second provision was that the program had to have some life before funding.

In other words, most of them that are effective started as voluntary programs and that even if funds are withdrawn, the program will continue because it comes up out of a commitment to the people living there.

Also the fact that they are not really talking about ways through needing a lot of funds. Sometimes it's just a little to enable them to print a brochure or to establish a van service or something. So I think it's using some surrogate organizations and setting up the criteria that will allow them to do it.

I looked at the criteria that the Office of Substance Abuse, HUD, as deeply as Jack Kemp's commitment is for drug abuse, none of the funds that HUD has for antidrug efforts could get to any of the groups in public housing that have demonstrated that they can kick the drug dealers out and also convince women and young men that they should be more responsible. None of those funds, not a dime, could get to them.

I suggest that maybe going through some surrogate organization and have them evaluated like we did ours—I suggest you look at the Office of Juvenile Justice model as one example.

Mr. HASTERT. Thank you. Thank you, Mr. Chairman.

Mr. DURBIN. Thank you, Mr. Chairman. During our recent onsite visit by this Select Committee in Detroit, we had an opportunity to take a very close look at the Eleonore Hutzel program and I think came away very impressed with the efforts that were made.

During the course of the day and the testimony that we received, some of the problems outlined by Mr. Gates in his testimony were described to the Select Committee. I'd like to follow up my colleague, Mr. Hastert's, questions by addressing Mr. Gates again.

I understand that you have proposed a few amendments to the Medicaid law that would permit Medicaid reimbursement for most of the substance abuse treatment centers for pregnant women. I am, of course, interested in pursuing that topic and legislation.

What effect do you think these legislative changes would have on the delivery of drug treatment to pregnant women?

Mr. GATES. The first effect would be to create that sustainable funding base so that programs will know from year to year that there will be a certain amount of money that they can count on. That enables them to hire top-quality people because people are not attracted to jobs where they don't know where their next paycheck is coming from.

So, having that really sustainable base is very important when you rely on other funding sources such as, for example, the ADAMHA block grant. As important as that is, and it is very important, that's subject to yearly appropriation. The amounts can go up and down. It lead a great deal of uncertainty. So, having that kind of certainty is very important.

Mr. DURBIN. In support of what you said, I believe there was testimony before this Select Committee at the Detroit hearing that only one-third of those who should be in treatment were in fact receiving treatment in the State of Michigan from all sources; federal, state and local sources.

It suggests that some of the resources that we need can only be anticipated or provided if there is a sustainable funding source, which leads to my next question. It's been our experience in the Budget Committee and through other committees of Congress that merely providing an incentive to states for a dollar-for-dollar match for the extension of benefits to pregnant mothers, for example, will lead some of the more progressive and forward-looking states to do the right thing, in the words of Mr. Lee, which are constantly quoted on Capitol Hill.

Many other states will ignore this, which has led us, in many instances, Mr. Waxman and others, Mr. Miller, to suggest that merely making these programs optional for the states doesn't go far enough. We need to push it further. I'd like to ask you your own opinion as to whether or not we should make this sort of Medicaid reimbursement for substance abuse treatment for pregnant women mandatory when it comes to state participation?

Mr. GATES. In my opinion, yes, it should be mandatory. The CBO cost estimate that was done for Senator Moynihan's amendment came up with a figure. They estimated that only about 50 percent of the—I shouldn't say 50 percent of the states because they didn't do it state by state.

But in terms of the number of Medicaid-eligible people who would be covered by a state option, only about 50 percent of the people, Medicaid-eligible people, would be covered if substance abuse treatment was made an option. Obviously, that leaves half of the people we're trying to reach out in the cold again.

It's just too critical of an issue to leave it at the state's discretion, unfortunately.

Mr. DURBIN. Thank you. I might conclude by noting for the record that we have greatly increased the federal commitment to the so-called Drug War or Drug Crisis in America. Under the president's proposed budget, the amount we are to spend in the next fiscal year, subject to the summit agreement, may exceed $9 billion.

The largest elements for increase within the president's drug war are for intelligence gathering overseas and international operations. The amount of increases for treatment and education are in single digits in comparison to these other programs.

It strikes me that if we are to have a coordinated program going after all of the various problems, which we've identified time and again, that we have to extend not only the legislative opportunity but, in many cases, the resources and perhaps even a mandate to make that happen.

I would like to thank you for also saying in the course of your testimony—Mrs. Boggs was kind enough to note here that there is a need to redefine the mental treatment exclusion in the Medicaid coverage, which I think is central to this discussion. We'll be working with you in the weeks to come. I thank all the members of the panel for their help.

Mr. SMITH of Texas. Thank you, Mr. Chairman. Mr. Woodson, I'd like to go back to your testimony for a minute. Toward the end, you make a number of recommendations, one of which is to give priority to border babies and adoption placement. Placement authority should be given to licensed community-based adoption centers.

I just thought you'd be interested in knowing that a bill that is being introduced today by a ranking minority member of this Select Committee, Tom Bliley, will go a long way towards accomplishing your recommendation. The bill is the Abandoned Babies Adoption Act which would require that states amend their laws and policies to expedite the procedures to find and place abandoned infants in permanent adoptive homes.

That particular piece of legislation is being cosponsored by my colleagues to my left and my right, Dennis Hastert on my left and Peter Smith on my right, as well as by me. So I think that is a way we can achieve some of the progress we'd all like to see.

My first question really goes back to a statement you made a while ago when you asked the rhetorical question, how does government execute that policy, referring to the policy you recommended. Then you mentioned specific programs that seem to continue in perpetuity simply because they continued to be funded for no apparent reason even if they weren't serving their purpose.

Are there any programs that you could point to that you feel that have been taken advantage of or that should not continue?

Mr. WOODSON. Yes. I could spend the whole day discussing that. I think on the affirmative side, certainly Head Start has been a very effective program. We've been very good in terms of reducing poverty among the elderly and improving service to the elderly. We've been very good in that population.

One of the programs that I think takes a serious reexamination to something has to do with the whole foster care adoption issue. There is an assumption afoot that the reason that we have so many of these boarder babies and the reason that we have so many kinds backlogged in the foster care system, particularly black youngsters, is because of the dearth of blacks willing to adopt them. That is patently untrue.

We have black parents backlogged on waiting lists throughout this country. It is because of the kind of confused red tape and disincentives that agencies have for releasing these children that we have the presence of the problem. A survey done by Dr. Robert B. Hill, I think very important, of the informal adoption—in other words, how many people care for nonrelatives in our society?

There are about 3 million; 1.1 million are blacks caring for nonrelatives. In other words, blacks are 12 percent of the population, yet they care for almost one-third of the kids. The profile of these people, they are single parent households in many cases. They don't have the benefit of having any additional financial support.

Child abuse among the informal network is less than with their regular parents. So the black community has demonstrated a capacity to do it. Homes of Black Children in Detroit has demonstrated when you remove the barriers, remove the red tape, that black parents will adopt in record numbers. That program is replicated here in Washington, D.C. In five years, it began to place more black children in permanent homes than the other 13 adoption agencies in the District. Yet, even though the demand increased for their services, funding for that particular effort did not increase. In fact, the staff's responsibility was cut.

Also, a lot of the money in the system does not go directly to the providers in their home. You will find that many states, we pay more to board a dog or household pets than we pay foster parents to care for children. The bulk of the money goes to the agencies providing the service. As long as those kind of disincentives exist, we're going to have the problem.

Again, most of the people who come before the Congress for hearings like this are not the foster care providers. They are the agencies who are saying our problem is we need better service. We need better trained social workers, better coordination of services, better training, all these other things. I'm telling you as a trained social worker, that ain't the problem.

Mr. SMITH of Texas. Mr. Woodson, you mentioned the cost of bureaucracy a minute ago. I was going to give you another statistic to add to your list. That is, I recently read that if the welfare payments or transfer payments that were appropriated by Congress were made directly to the needy families that deserve them, each needy family of four would receive $24,000 per year.

As it stands, they get $8,000 per year because of the bureaucracy involved. That goes back to a point you made a while ago. Let me thank you for being such an able spokesman on so many issues. I very much appreciate your testimony.

Chairman MILLER. I just want to state, I would not want to leave the impression that the answers to the problems being raised in this hearing is them against us, because I think it would be very unfortunate if members of this panel left believing that somehow the problem is professionals who work in the field. That would be very, very unjust to those individuals.

This committee has been dedicated to the notion that almost all of the problems that we confront require a mosaic of providers across this country. We listened to a woman who works in the hospital in South Bronx delivering AIDS babies. She is a professional. She is a medical doctor, researcher and an OB-GYN delivering children.

Her professionals have adopted so many AIDS-related babies that they are now trying to buy a house so that they can have child care because the nursing staff is so burdened by the children they have adopted. So the notion that professionals are really only doing this for money or to maintain caseloads is an outrageous indictment.

It's interesting, when I travel through my community, I don't know whether they have the same zip code but they live in the same community. Whether it's the YMCA or the Girls' Club or the Boys' Club or the neighborhood house or the South Side Center—you know what?—they're busting their butts and they are doing it with federal money, state money, city money, foundation money and corporate money and they still can't provide services to everybody who is knocking on the door.

So the notion that somehow if you could just let people in the community do it, in a lot of these communities, those people work trying to keep their own families together. I just don't understand that kind of attack. I don't understand it. It's like attacking the Clean Air Act because the air is not clean.

Measure our progress against Hungary or Poland or Czechoslovakia or the Soviet Union, right, the air isn't clean but it's a hell of a lot better than it might have been. There's a lot of other things we can do.

We have witnessed time and again indigenous local programs run by churches, neighborhood organizations, individuals and they should not be excluded. But to suggest that if that was the only model that was portrayed, that somehow the problem would be eradicated, I think it's an unfair indictment of organizations I essentially think are basically the same, that are working almost against unbelievable caseloads and odd hours that I just don't understand that discussion. I'm at a loss to determine that.

Mr. HASTERT. Mr. Chairman, I can see your frustration, but I've also seen the frustration of worthwhile groups. All of a sudden, "the professional organizations of bureaucracy," or those people who view new legislation as a way to raise revenues, design an institution and program, and absorb all the funds.

They sometimes act as a tremendous sponge. When you get down to the agencies that Mr. Woodson's talking about, there ain't no money left.

Chairman MILLER. I understand that, but the suggestion is also strongly made that the people who are working on that problem really aren't doing their job and that they are only doing it to maintain caseloads, which I think is incredibly unfair to people who are putting in the time and the effort and achieving the successes that many, many of those people, in fact, are achieving. That's all.

Mrs. BOGGS. Mr. Chairman, certainly I did not want to suggest that I don't have tremendous admiration for the professionals. So many of them work themselves, literally, to death. They take on extra hours. They take on extra responsibilities. They are absolutely remarkable, but they are oftentimes excluded from being able to be helpful to the neighborhood people because of the rules and regulations that they must follow.

I think that what this committee has done, and certainly under your guidance, is to have all sorts of organizations come from the smallest group of young people against violence up in New York to the large organizations and national and international associations to come before us to tell us their suggestions, their needs, their success stories and their frustrations.

I think that we, therefore, have a holistic view of what the problems are spread across the board of all of the people who are trying to provide some help and who are trying to solve the problems in the best possible way and to tell us what help they think they need from this committee and from the Congress of the United States.

Mr. SMITH of Vermont. Would the gentlelady yield for a second?

Mrs. BOGGS. Certainly.

Mr. SMITH of Vermont. I think you're hitting the nail on the head. I did not hear anything in the time I've been here to suggest that there was a bashing of professionals, but rather that inadvertently we have created, through federal regulatory structure and just decreasing over the years, programs and delivery systems which are not always friendly, user friendly to community-based organizations.

There is no malice to the people who are in those systems delivering those services. At some point where we are in a world where business and, in fact, the nonprofit sector is reinventing itself at a rate that is astonishing in terms of ways to be appropriate in the 21st century, we have to understand, as we hear the cries for help from our communities, that one of the things that government hasn't been good at is allowing itself to reinvent its own way of doing business at the point where the rubber hits the road.

While I would certainly agree with what you said if I thought that that was the case, I hope we don't miss a much, much more, for my money anyway, more important point which is that we need to figure out how to let our programs at the most local level be responsive and be renewing and be reinventing.

That would never be an argument for less money on my part. Obviously, it takes resources to do these things. Somehow we have to give those professionals as well as the community-based organizations which are out beyond the reach of professionals the capacity and the flexibility and the tools to bind up with each other and go down the road together.

Regrettably, we don't achieve that. Regardless of what we wish, it doesn't happen in an awful lot of cases. I felt that that was what I was hearing.

Chairman MILLER. There's two arguments here. One is that some people aren't participating in the solution because of bureaucratic restrictions or what have you or program design, however you want to do that. That's fine. The other one is the suggestion that a lot of the professional people are only doing this for caseload money, management.

Mr. WOODSON. No, no. May I comment?

Chairman MILLER. Well, we can read back the record. So the fact is, there are two arguments. I think that that's a slight of people who are working very, very hard. I don't think this is a contest between—because most of these programs, in fact, are an integration of community people and professionals.

I'm not interested—it's not a question of whether you lived in the zip code. The question is, can you provide necessary services? Even if you lived in the zip code, you might want a trained person looking at these problems. As was told us in law school, the last thing poor people needed was a poor attorney. So study hard; then you can help.

So there's a mix. If you look at most of these programs, in fact, there is a mix of people.

Mr. WOODSON. Mr. Miller, if I may. My comments were more to what Mrs. Boggs was saying. It was not to bash anybody. I'm not a person who—in all my years—the ghetto isn't the problem. It's the solution. It is not a bipolar issue here. The issue is effective strategies to intervene.

Most of the information that I have received have come from fellow professionals who come to me privately or write letters to the office in saying that they are all—most of them go into it because they want to serve people. They are limited by institutional practices that causes good people to do bad things.

So, what I'm really talking about are institutional arrangements so that an administrator, even if they wanted to reduce the caseloads of a foster care agency—if you have 1,000 youngsters in foster care and you receive reimbursement from the government.

With that reimbursement, you pay all of your salaries and pay your rent and what have you, the question that this administrator posed to me, what incentives do we have to reduce our caseload and place 500 children in adoption? Maybe what we need to do then is pay agencies monies for getting children out of foster care into adoption.

In other words, what I'm making a plea for are changing the rules of the game so that the people in those agencies can do what they want to do for kids. So, it's not a matter of bashing professionals. It's a matter of looking for more balance, looking for more choice.

But overall, we all should be driven by outcomes. I very seldom hear discussions of outcomes. Over what period of time have various agencies been funded and what has been your record of success? So, that's where I think the argument, Mr. Miller, has to be. I agree with you. I would not bash professionals. I am one myself. That would be hypocritical. But I've got to be honest with myself and say that a lot of what we do in the name of helping people in a lot of the institutional practices injure with the helping hand. I think it would be a disservice to the poor for us to be defensive about that when we've got to be honest to confront this crisis.

Chairman MILLER. There's no argument on that point. That's the purpose of this committee. I guess I'll stand by my characterization and others can differ with it. Thank you very much for your help.

The next panel will be made up of Kary Moss, Staff Attorney, Women's Rights Project, American Civil Liberties Union; James Ryan, DuPage County State's Attorney from Wheaton, Illinois; Jo Ann Kauffman, President of the National Association for Native American Children of Alcoholics; and Dr. Albert Pruitt, Chairman of the Department of Pediatrics Medical College of Georgia.

Ms. Moss, we'll begin with you. Your statements will be placed in the record in their entirety. You proceed in the manner in which you're most comfortable.

STATEMENT OF KARY MOSS, J.D., STAFF ATTORNEY, WOMEN'S RIGHTS PROJECT, AMERICAN CIVIL LIBERTIES UNION, NEW YORK, NY

Ms. Moss. Thank you, Mr. Chairman. I would like to thank you and the committee for inviting me to come and speak today on behalf of the American Civil Liberties Union. As you know the American Civil Liberties Union is a national organization composed of 275,000 members dedicated to protecting the Bill of Rights.

Specifically, I am an attorney with the Women's Rights Project. Our focus is on issues affecting low-income women and poor women of color. I'm here today to talk to you about two different issues. The first is the discriminatory exlusion of pregnant women by drug and alcohol treatment programs. The second is to talk to you a little bit about the results of a state survey that we recently undertook, examining what the states are doing on the issue of alcohol and drug-dependent women and their children.

As a background matter, I would just like to say that there are two trends that are going on right now that are of real concern to us. The first is the institution of criminal prosecutions against alcohol and drug-dependent women for the crime of being alcohol and drug dependent while they are pregnant. To date there have been about 50 of these prosecutions. It is our position and belief that these prosecutions violate women's rights to privacy and bodily integrity and often the due process of the laws.

We are also concerned by a second trend, which is the institution of child neglect and abuse proceedings against these women, instituted only because they were not able to obtain alcohol and drug treatment while they were pregnant. The only evidence provided against these women is a positive drug test taken at the time of birth.

In many cases the social service agencies fail to undertake a real review of the parenting abilities of the parent or of the foster care system and the ability of the foster care system to adequately meet the best interests of the child.

We are concerned that these women and their children obtain the best health care possible; that we have healthy mothers and that we have healthy babies. We believe that criminal prosecutions and the child neglect proceedings that are undertaken without a real review of the parenting abilities of the mother or the father will drive women away from health care and penalize them for deciding to continue their pregnancies.

One of the issues that is of real concern to us is the lack of treatment available to pregnant women. In the context of the criminal prosecutions and neglect proceedings, we have an environment in which many women cannot obtain treatment. This situation has been very well documented by this committee and discussed this morning.

Yet what has not been discussed is the practice of many alcohol and drug treatment programs to intentionally exclude pregnant women. They refuse to provide treatment for generally two reasons. The first is because they view pregnant women as too complicated, as requiring too many special services. These programs lack the resources or the desire to develop programs that can specifically meet needs of pregnant women so they refuse to provide them with treatment.

The other reason that many programs exclude pregnant women is that they fear that the treatment process may harm the fetus, prompting lawsuits by alcohol and drug-dependent women or by their children.

As a result, in New York we recently instituted the first lawsuit in the country challenging the discriminatory treatment of this population, relying New York State Human Rights Public Accommodations Law § 296, which prohibits discrimination on the basis of pregnancy. We are representing three women, two crack addicts and one alcoholic. The two women who are crack addicts were not able to get treatment while they were pregnant and delivered babies that had positive toxicologies at birth. The woman who was an alcoholic is still pregnant and has been unable to obtain any detox service during her pregnancy. This failure has meant that she has been unable to gain admission into any of the available drug-free programs and, therefore, has not obtained any treatment at all.

Unfortunately, the New York Public Accommodations Law that we are using to challenge discrimination against pregnant women is available only in New York. Thirty-five other states have public accommodations laws, but not all these apply to pregnancy. It therefore becomes very difficult for alcohol and drug-dependent women to challenge their exclusion from treatment programs.

The written testimony that I have submitted discusses these laws in great detail. The testimony also discusses the effectiveness of state equal rights amendments and state equal protection clauses, each of which provide a vehicle to challenge discriminatory practices. However, each of these laws have serious limitations, particularly insofar as they require state action, which means that private facilities may be completely immune from the laws or they don't apply to pregnancy. Therefore, we recommend that Congress enact a federal bill which would explicitly prohibit discrimination against pregnant women in alcohol and drug treatment programs.

The other thing that is happening is that states are not enacting laws that would prohibit discrimination against pregnant women, which is another reason we need a federal law. Instead, states are imposing very punitive measures on this population. They are, for example, instituting mandatory reporting requirements so that if a woman goes into a hospital, and delivers a baby with a positive toxicology, the results may be turned over to the law enforcement officials, thus triggering criminal prosecution.

To date, Minnesota and Missouri have passed the most punitive laws. At least seven states have enacted laws that would make a positive toxicology prima facie evidence of neglect without requiring social service agencies to undertake a more searching review of parental fitness.

Both of these developments—the reporting requirements and the negative laws—may violate the woman's constitutional rights. We also believe that they penalize, primarily, poor women and women of color who use public hospitals, who tend to report women more than private hospitals.

A recent study, undertaken by the National Association for Perinatal Addiction of Pinellas County, Florida, for example, found that although the incidence of drug use among white women and black women was the same, black women were 10 times more likely to be reported to social services than were white women. For these reasons, we oppose these laws.

In Ohio, Georgia, Rhode Island and Iowa, laws have been proposed that would make drug use during pregnancy a felony. The law proposed in Ohio would actually mandate forced sterilization of pregnant women. None of these proposals have succeeded, but they are all, I think, indicative of a trend to view this problem not as a health issue but as one deserving of punitive measures.

In closing, I recommend that this committee propose a bill that would prohibit discrimination against pregnant women in alcohol and drug treatment programs; prohibit the mandatory reporting of positive drug tests; require State social service agencies to examine foster care services and parenting abilities before taking a child away from the parents and increase resources to treatment programs so that they are able to provide the full range of comprehensive services that alcohol and drug-dependent women need.

Thank you.

[Prepared statement of Kary Moss follows:]

Prepared Statement of Kary L. Moss, Esq., Staff Attorney, Women's Rights Project, American Civil Liberties Union, New York, NY, and Lynn M. Paltrow, Esq., Staff Attorney, Reproductive Freedom Project, American Civil Liberties Union, New York, NY, and Judy Crockett, Legislative Representative, American Civil Liberties Union, Washington, DC

Introduction

Mr. Chairman, members of the Subcommittee, we appreciate the opportunity to present the views of the American Civil Liberties Union upon the question of discrimination against pregnant women in alcohol and drug treatment programs and upon the implications of the recent trend in state legislatures to impose punitive measures upon alcohol and drug dependent pregnant women. The American Civil Liberties Union is a non-partisan organization with more than 275,000 members devoted to protecting the Bill of Rights.

Specifically, our testimony will focus on the inadequacy of state anti-discrimination laws as a vehicle to challenge discriminatory practices by alcohol and drug treatment programs. In addition, we will discuss state bills introduced this past year that make it a crime for a pregnant women with an alcohol or drug dependency problem to continue their pregnancies, amend existing child neglect laws to include prenatal alcohol or drug use, and require health care professionals to report positive test results of newborns to social service agencies or state prosecutors.

Mr. Chairman, we are very concerned that alcohol and drug dependent women obtain the prenatal and medical care that they need in order to promote their health and the health of their children.1/ Yet many alcohol and drug treatment programs close

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1/ Fetal alcohol syndrome may be averted by discontinuance of alcohol use at any stage in pregnancy. With regard to cocaine (continued...)

their doors to pregnant women.[2] Although many programs were not designed to address the needs of alcohol and drug dependent pregnant women, the programs may provide the only hope, in a given geographic area, for help for these women.

Even where services are available, they are often glaringly insufficient. For example, few provide prenatal care, child care, or other services found essential to successful treatment for women.[3] The National Institute for Drug Abuse recognized over a decade ago that the inability to obtain child care prevents many women from participating in drug treatment programs. Nevertheless, only two of the eighty-seven drug treatment programs in New York City have child care facilities for their patients.[4] Similiarly, in San Diego County,

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[1] (...continued)
use, Dr. Ira Chasnoff, in his study of seventy-five cocaine-using women enrolled in a comprehensive perinatal care program, found that women who used cocaine throughout their pregnancy, as compared to women who used cocaine only in the first trimester, had a greater incidence of low birth weight babies and significant deficiencies in intrauterine growth. He concluded that early intervention in early pregnancy with cessation of cocaine use will result in improved obstetrical and neonatal outcomes. Chasnoff, I., et al., "Temporal Patterns of Cocaine Use in Pregnancy," *JAMA*, March 24/31 1989, Vol 261, No. 12.

[2] *See* Miller, G., "Addicted Infants and their Mothers," *Zero to Three*, Vol. IX, No. 5 at 20 (June 1989)(two thirds of the 18 hospitals surveyed reported that they had no place to refuse drug dependent women for treatment). The Coalition for Alcohol and Drug Dependent Women and their Children, a national effort by over forty child welfare, legal advocacy, and drug treatment programs to prevent the punishment of alcohol and drug dependent women, is currently surveying the availability and sufficiency of existing programs.

[3] Leff, L., "Treating Drug Addiction with the Woman in Mind," *The Washington Post*, March 5, 1990 at E1.

[4] Chavkin, *Help, Don't Jail Addicted Mothers*, New York Times, July 18, 1989, at A21, col.2.

California, there is only one residential facility for women with children, which has only twenty-six treatment slots, and there is as long as a six month waiting list for admission.[5] The problems in obtaining care are even greater for women in rural communities.

The American Civil Liberties Union's national survey of criminal prosecutions, *see* Appendix A, and survey of recent state laws, *see* Appendix B, revealed that alcohol and drug dependent women are simply not getting the help they need. Despite the fact that few programs accept alcohol and drug dependent women, alcohol and drug dependent women who become pregnant are threatened with, or subjected to, punitive measures. *See* Appendix A.

The ACLU opposes the discriminatory treatment of alcohol and drug dependent women solely because they are pregnant, whether such discrimination occurs through refusal to treat this population, criminal prosecution, or selective reporting. Pregnant women should not be singled out for special or punitive measures. The constitution protects the rights of all persons to the equal protection of the laws and to privacy. Women do not forgo these rights when they become pregnant.[6]

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[5] Schecter, *Help is Hard to Find for Addict Mothers*, L.A. Times-San Diego County, Dec. 12, 1986, at 1, col. .

[6] *In re A.C.*, No. 87-609, slip op. 1105 (D.C. Ct. App. April 26, 1990).

The federal government should prohibit discrimination against pregnant women by alcohol and drug treatment programs

Discrimination on the basis of sex, including pregnancy, is prohibited under federal law, e.g., 42 U.S.C. §2000e (employment), as well as under many state human rights laws. See e.g., Brooklyn Union Gas Co. v. N.Y.S. Human Rights Appeal Board, 41 N.Y.2d 84, 359 N.E.2d 393, 390 N.Y.S.2d 884, 886 (1976).7/ Nevertheless, many alcohol and drug treatment programs still discriminate against pregnant women. According to Dr. Wendy Chavkin, a former Rockefeller Fellow at the Columbia University School of Public Health, 95% of all drug treatment programs in New York City (approximately 78 programs) provide no care for pregnant women. 54% refuse to treat pregnant women; 67% refuse to treat pregnant women on Medicaid and 87% have no services available to pregnant women addicted to crack who are medicaid-eligible. 44% provide no prenatal care.8/ Only one program in

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7/ E.g., Cal. Civ. Code §§51-52 (West 1989); Colo. Rev. Stat. §24-34-401(2)(1988); Ill. Ann. Stat. Ch. 68 §§1-101 to 9-102 (Smith-Hurd 1989); Mass. Gen. Laws. Ann. ch. 272 §92A (Supp. 1989); N.Y. Exec. Law §296. The legislative history of the Pregnancy Discrimination Act noted that Alaska, Connecticut, Maryland, Minnesota, Oregon, and Montana specifically include pregnancy in their Fair Employment Practice (FEP) Laws. Twelve additional states have interpreted the prohibitions on sex discrimination in their FEP laws to require equal treatment of pregnant workers. In three instances, state courts have so interpreted the state FEP laws (New York, Pennsylvania, Wisconsin); in at least nine additional states, the state enforcement agency has so construed the state law. Those states are: Illinois, Indiana, Iowa, Kansas, Massachusetts, Michigan, Missouri, South Dakota and Washington. H.Rep. No. 95-948, 95th Cong., 2d Sess. 11 (1978).

8/ Chavkin, W., "Help, Don't Jail, Addicted Mothers," New York Times, August 1989 at A21.

New York City, Oddyssy House, provides residential drug treatment programs for pregnant women and their children. It has approximately 25 beds. The only available alternatives are day treatment facilities, that are less effective than residential programs, and many will not treat pregnant women at all, especially if they are not drug-free. The lack of services for pregnant women is true nationwide.

Discrimination appears to be most common when the treatment needed is detoxification, which may involve the use of mild sedatives, and the treatment program lacks prenatal care or obstetrical services. Programs often fear that such treatment may harm the fetus and therefore subject them to liability.

This defense is very problematic for a number of reasons: first, the professed concern for the fetus makes little sense given the serious harm that can occur if crack addiction or other alcohol or drug problems go untreated; second, it is possible to provide detoxification services to pregnant women safely without risk to the woman or fetus; third, traditional informed consent doctrine should protect physicians and hospitals that properly advise patients of the risks associated with, and the alternatives to, a course of treatment even if the patient makes the "wrong" choice; fourth, a program's concern about liability is suspect since no program has ever been sued by a post-partum woman or child after having received treatment; finally, programs can set up referral networks, part-time obstetrical care, or develop other resources to ensure that patients obtain the full range of services that they need.

In the only challenge to this practice to date, the American Civil Liberties Union has filed a class action law suit against four private alcohol and drug treatment programs in New York City.[9] The lawsuit relies on the New York State public accomodations law, N.Y. Exec. Law §296, which prohibits discrimination because of pregnancy in private facilities open to the general public.

Yet we need a federal law to address this discrimination because the problem is nationwide and current federal laws are either limited in scope, *e.g.*, 42 U.S.C. §2000e, or are inadequate for this purpose.[10] State by state challenges to the discriminatory treatment of alcohol and drug dependent pregnant women are costly, time-consuming, and will have precedential value only with regard to the particular state. The difficulties are compounded by the variety of state anti-discrimination laws, only some of which apply to private facilities (public accommodation laws) and only some of which apply to sex and pregnancy. For example, only thirty-five states have public accommodations laws, *see* Appendix C, that prohibit discrimination on the basis of sex.

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[9] *Elaine W., et al. v. North General Hospital, et al.*, Index No. 6230/90 (N.Y. Sup. Ct., filed November 23, 1989).

[10] While the Rehabilitation Act, 29 U.S.C. §794, is usually an essential tool for challenging discrimination against "otherwise qualified" drug abusers, it is not available in cases involving discrimination in drug treatment programs. While persons with histories of drug use are "handicapped" individuals within the meaning of the Federal Rehabilitation Act, it would not make sense to argue that a pregnant woman had been excluded from a drug treatment program "solely by reason" of her drug use when the purpose of such a suit had been to challenge exclusion on the basis of pregnancy. Pregnancy does not fall within the definition of a "handicap."

Public alcohol and drug treatment programs that exclude pregnant women may also be challenged under state equal protection clauses.[11] But this approach will also be piecemeal

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[11] In her excellent article, "Sex Discrimination and State Constitutions: State Pathways Through Federal Roadblocks," *13 N.Y.U. Rev. of L. Soc. Change 115*, 119-21 (1984-85)(hereinafter Sherwin), Elizabeth Sherwin notes that state equal protection clauses fall roughly into four categories.

First, there are "clauses which affirmatively prohibit interference with the civil rights of any individual" and which most clearly resemble the federal model, i.e. Conn. Const. art.I, §20, Fla. Const. art.I, §2 (arguably fits both first and second categories); Ga. Const. art.I, §1, ¶2; Hawaii Const. art.I, §5; Ill. Const. art.I, §2; La. Const. art.I, §3; Me. Const. art.I, §6-A; Md. Const. Declaration of Rights, art.46 (applies equal protection specifically to women); Mass. Const. pt. 1, art.1 (arguably fits third category); Mich. Const. art.I, §2; Minn. Const. art.I, §2; Mont. Const. art.II, §4; N.J. Const. art.I, ¶5; N.M. Const. art.II, §18; N.Y. Const. art.I, §11; Pa. Const. art.I, §26; S.C. Const. art.I, §3; W.Va. Const. art.III, §1 (arguably fits second or third categories); Wyo. Const. art.I, §3.

Second, there are "provisions which enumerate the civil rights to which every citizen is entitled but do not by their terms prohibit interference with those rights," i.e.: Ala. Const. art.1, §1; Alaska Const. art.I, §1; Colo. Const. art.II, §3; Idaho Const. art.I, §1; Ill. Const. art.I, §1; Iowa Const. art.I, §1; Kan. Const. Bill of Rights, §1; Me. Const. art.I, §1; Neb. Const. art. I, §1; Nev. Const. art.I, §1; N.H. Const. pt. 1, art.2; N.C. Const. art.I, §1; Ohio Const. art.1, §1; Okla. Const. art.II, §2; Or. Const. art.1, §1; Pa. Const. art.I, §1; R.I. Const. art.I, §2; Vt. Const. ch. I, art.1; Va. Const. art.I, §1; Wis. Const. art.I, §1; Wyo. Const. art.I, §2. The mandatory force generally results from judicial interpretation.

Third, there are provisions known as "special evolvements" which have been interpreted to provide equal protection and prohibit the grant of special privileges to any citizen or group of citizens, i.e.: Ariz. Const. art.2, §13: Cal. Const. art.I, §7(b); Conn. Const. art.I, §1; Ind. Const. art.I, §23; Iowa Const. art.I, §6; Ky. Const. Bill of Rights, §3; N.D. Const. art. I, §21; Ohio Const. art.I, §2; Or. Const. art.I, §20; S.D. Const. art.VI, §18; Tex. Const. art.I, §3; Wash. Const. art.I, §12. As Sherwin notes, although these provisions have no federal counterparts, they are therefore closer to the federal equal protection clause than the rights-enumerating clauses because they are

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and inadequate because most, but not all, of these laws require state action. Most private facilities are immune from judicial scrutiny. Equal protection challenges to discriminatory treatment are also difficult because the standard of review varies state by state. For example, under the federal constitution,[12] and in most states,[13] gender-based laws are subject to "middle tier" review. The gender-based classification must serve "important governmental interests" and the discriminatory means employed must be substantially related to

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[11] (...continued)
inherently mandatory and prohibitory.

Fourth, state courts have read equal protection guarantees into state due process clauses, i.e.: *State ex rel. Harris v. Calendine*, 960 W.Va 172, 233 S.E.2d 318, 324 (W. Va. 1977)(construing W.Va. Const. art.III, §10); *Howard Sports Daily, Inc. v. Public Service Comm'n.*, 179 Md. 355, 358, 18 A.2d 210, 213 (1941)(construing Md. Const. Declaration of Rights, art.23 and U.S. Const. amend XIV); *Bruce v. Director, Dep't of Chesapeake Bay Affairs*, 261 Md. 585, 600, 276 A.2d 200, 208 (1971)(same). Mississippi and Nevada have due process clauses, but lack equal protection clauses, Miss. Const. art.III, §14 and Nev. Const. art. I, §8, and courts in these states have never ruled on whether the due process clause incorporates a guarantee of equal protection.

[12] *E.g.*, *Mississippi University for Women v. Hogan*, 458 U.S. 718 (1982); *Craig v. Boren*, 429 U.S. 190, 197 (1976).

[13] Some states do employ stricter standards that should protect women. *See e.g.*, *Sail'er Inn Inc. v. Kirby*, 5 Cal. 3d 1, 485 P.2d 529, 95 Cal.Rptr. 329 (1971)(first state judiciary to award suspect class status to gender discriminations); *Commonwealth v. Daniel*, 430 Pa. 642, 648-49, 243 A.2d 400, 402-03 (1968). *People v. Green*, 183 Colo. 25, 514 P.2d 769 (1973); *People v. Ellis*, 57 Ill. 2d 127, 311 N.E.2d 98 (1974), E. Sherwin notes, at 133-4, that some states place an absolute prohibition on gender classifications. *See e.g.*, *People v. Salinas*, 191 Colo. 171, 174, 551 P.2d 703, 706 (1976), *Commonwealth v. Butler*, 458 Pa. 289, 328 A.2d 851 (1974); *Henderson v. Henderson*, 458 Pa. 97, 101, 327 A.2d 60, 62 (1974), 65 Op.Md. Attorney General 103, 108 (1980), *Rand v. Rand*, 280 Md. 508, 374 A.2d 900 (1977), *Marchioro v. Chaney*, 90 Wash. 2d 298, 582 P.2d 487 (1978), Aff'd, 442 U.S. 191 (1979), *Darrin v. Gould*, 85 Wash.2d 859, 540 P.2d 882 (1975).

the achievement of those objectives. Although this intermediate standard should preclude discrimination in drug treatment programs, pregnancy is often not treated as sex discrimination.

State equal rights amendments (ERAs) provide another vehicle to challenge discrimination because of sex/pregnancy. However, only sixteen states have ERA's: Alaska, Colorado, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Montana, New Hampshire, New Mexico, Pennsylvania, Texas, Utah, Virginia, Washington, and Wyoming. The requirement of state action limits their utility as a means to challenge discriminatory programs.[14] Only Montana's ERA prohibits discrimination by "any person, firm, corporation, or institution."

As with state equal protection clauses, state ERA's are subject to varying standards of review. Three state courts -- Maryland, Pennsylvania and Washington -- have ruled that their ERA requires more than "strict scrutiny" review, barring all sex-based classifications except those based on a physical characteristic unique to one sex or implicating the constitutional right to privacy.[15] Four states -- Colorado, Illinois, Massachusetts, and Texas -- have declared that gender-based classifications, like race or religion, should be given "stringent" review.

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[14] Six state ERAs (Colorado, Hawaii, Illinois, New Hampshire, Virginia and Wyoming) are expressly limited to instances where government action is involved.

[15] *Rand v. Rand*, 280 Md. 508, 374 A.2d 900 (1977); *Henderson v. Henderson*, 458 Pa. 97, 101, 327 A.2d 60, 62 (1974); *Darrin v. Gould*, 85 Wash. 2d 859, 540 P.2d 882 (1975).

Thus, while there are many state laws that may be used to challenge programs that discriminate against pregnant women, each suffers significant limitations. No state has yet enacted a law explicitly prohibiting discrimination against pregnant women. Therefore, a federal law prohibiting discrimination on the basis of pregnancy would provide a constructive and efficient response to this problem. It would also relieve individual alcohol and drug dependent pregnant women of the burden of bringing a discrimination claim in the courts of every state in order to secure treatment.

The federal government should discourage the criminal prosecution of alcohol or drug dependent women who choose to continue their pregnancies

The federal government should take steps to stop the recent trend to subject alcohol and drug dependent women to criminal prosecution for their alcohol or drug use during pregnancy. To date, at least fifty women have been charged with crimes for their behavior during pregnancy. *See* Appendix A. The American Civil Liberties Union has been involved as counsel or advisor in most of these cases. Our national survey of these prosecutions confirm that women of color,[16] poor women, and battered women[17]

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[16] Eighty percent of the forty seven cases in which the race of the women could be identified involve a woman of color.

[17] A significant number of women arrested for their actions during pregnancy were in abusive relationships. Newspaper and court reports have documented that four of the white women prosecuted were beaten by their boyfriends; the actual number is likely higher. *State of Alaska v. Grubbs*, No. 4FA S89 415 Criminal (Sup. Ct. Aug. 25, 1989); *State of Wyoming v. Pfannenstiel*, No. 1-90-8CR (Laramie County Ct. complaint filed

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are the primary victims. In none of these cases have the men whose violence threatened the health of the fetus been charged with child endangerment.

None of the women arrested were charged with the crime of possession of illegal drugs. Instead, they were arrested for a new and independent crime: continuing their pregnancy while addicted to drugs. Because women are discriminated against in drug treatment programs, and because it is virtually impossible to stop using drugs without help, these prosecutions, in effect, punish women for their decision to continue a pregnancy.[18] These prosecutions thus violate constitutional privacy and liberty guarantees that protect the right to decide "whether to bear or beget a child."[19]

Prosecutions also deter pregnant women from getting what little health care is available. As Senator Herbert Kohl stated at Congressional hearings on perinatal substance abuse,

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[17] (...continued) Jan. 5, 1990); Charles Levendosky, Turning Women into 2-legged petri dishes, Sunday Star Tribune, Jan. 21, 1990 at A8; Commonwealth of Mass. v. Pelligrini, No. 87970 (Mass. Super. Ct. filed Aug. 21, 1989); Tom Coakley, Suspect is said to be battered, frightened, Boston Globe, Aug. 23, 1989 at 22; State of California v. Stewart, No. M508197 (San Diego Mun. Ct., Feb. 26, 1987).

[18] Statements by the prosecutor in one criminal case illustrate: "When she delivered that baby, she broke the law in the state." The court agreed, noting that the defendant "made a choice to become pregnant and to allow those pregnancies to come to term." State v. Johnson, No. E89-890-CFA. Although there have been nearly fifty arrests and prosecutions of women for their behavior during pregnancy, Johnson was the first to be convicted after trial.

[19] Eisenstadt v. Baird, 405 U.S. 438, 453 (1972); Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 640 (1973).

"[m]others -- afraid of criminal prosecution -- fail to seek the very prenatal care that could help their babies and them."[20] Women are also discouraged from seeking help because of the fear that they will lose custody of their children. According to Ricardo Quiroga, who is helping to set up an alcohol recovery house for Hispanic women with children in Massachusetts, women "don't want to seek help for fear they will lose their children."[21]

Prosecutions also undermine doctor-patient trust. Those women who seek medical care are often too frightened to speak openly to their doctors about their alcohol or drug dependency problems. In Florida, for example, after "[u]niformed officers wearing guns entered Bayfront Medical Center . . . to investigate new mothers suspected of cocaine abuse," doctors reported that they could no longer "depend on the mothers to tell them the truth about their drug use . . . because the word ha[d] gotten around that the police will have to be notified."[22] Without honest communication between doctor and patient, it will be impossible to provide pregnant women with the the medical care they need to to ensure the health of the mothers and babies.[23]

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[20] Missing Links: Coordinating Federal Drug Policy for Women, Infants and Children, Hearing Before Senate Committee on Governmental Affairs, 101st Cong., 1st Sess. (July 31, 1989)(Opening statement of Senator Herb Kohl) at 5.

[21] Malaspina, Clean Living, Globe Magazine, Nov. 5, 1989 at 20.

[22] Angry Doctors Cut Drug Tests After Police Interview Moms, St. Petersburg Times, May 13, 1989 at 1B.

Criminal prosection, for the "crime" of being alcohol or drug dependent *and* *pregnant* reflects a lack of understanding that drug and alcohol dependency is not demonstrative of "willful" behavior but rather, is an illness whose cure has confounded generations of doctors and psychologists.[24] We do not suggest that because a woman cannot be prosecuted for a crime, such as possession of illegal drugs, simply because she is pregnant. Rather it is the focus on the drug use during *pregnancy*, as the basis for the prosecution, that is contrary to well-established principles of constitutional law.

Criminal prosecution is also ultimately premised on the assumption that pregnant addicts are indifferent to the health of their fetuses, or that the women willfully seek to cause their fetuses harm.[25] These assumptions are incorrect: real resource constraints may prevent women from securing treatment or proper care during their pregnancies. Even when women can secure treatment, recovery may be constrained by the very nature of the addiction. Addiction typically involves loss of control over use of a drug and continued involvement with a drug *even when* there are serious consequences.[26] To treat alcohol and drug dependent pregnant women as indifferent and deliberate wrongdoers is to misunderstand the nature of addiction.

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[23] Physician failure to maintain patient confidentiality has been identified as one of the barriers to pregnant women seeking prenatal care. Curry, *Nonfinancial Barriers to Prenatal Care*, 15 Women & Health 85, 92 (1989). Health care workers in localities in which women who used drugs during pregnancy have been prosecuted, have repeatedly testified that pregnant women were driven away from their programs. *See* Declaration of Lydia Roper, L.C.S.W., *State v. Stewart*, M508197 (San Diego Mun. Ct.); Declaration of Cathy Mauer, M.S., *State v. Stewart*, M508196 (San Diego Munc. Ct.); Affidavit of Ira Chasnoff, M.D., *State v. Hardy*, 89-2931-FY (Muskegon County Dist. Ct. Mich.)

[24] *See* *Robinson v. California*, 370 U.S. 660 (1962).

[25] *E.g.*, Boyer at note 11.

For all of these reasons, the American Civil Liberties Union opposes criminal prosecutions of alcohol or drug dependent women whose only "crime" is choosing to continue a pregnancy. We support a woman's constitutional right to decide whether or not to terminate a pregnancy free of governmental interference or coercion.

Yet, in several states it may become even easier to criminally prosecute these women. Bills that would make drug use during pregnancy a felony have been introduced in Ohio,[27] Georgia,[28] and Louisiana[29] and Rhode Island,[30] and perhaps other states as well. The bill pending in Ohio, for example, would actually mandate forced sterilization of women who are not able to overcome their dependency on drugs. Any woman who uses drugs while pregnant, causing a child to be addicted at birth would be prosecuted as a felon. In addition to the prison term ordinarily authorized as punishment for felony offenses, the legislation authorizes several alternative sentences: a court could sentence any woman who pleads guilty to or was convicted of the offense to "elect" to "successfully complete a drug addiction program," to "undergo a tubal ligation," or to "participate in a five year program of monitored contraceptive use approved by the court . . . and during the five year period abstain from the addictive use of drugs of abuse." The proposed legislation gives a repeat offender only two "choices:" she may "undergo a tubal ligation" or participate in the monitored contraceptive program described above.

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[26] Cohen, S., M.D., *The Chemistry of Addiction* 59 (Care Institute 1988). Drug dependency and alcoholism include tolerance development and are influenced by genetic predispositions and environmental factors outside the addicts' control. *Id.*

[27] SB 324, 118th General Assembly, Regular Session 1989-90 (Ohio), introduced by Senator Cooper Snyder.

[28] In Georgia, a bill was recently defeated that would have provided that any woman who uses a controlled substance or dangerous drug while pregnant, and who as a result gives birth to a child who "tests positive for addiction," is guilty of the criminal offense of distributing a controlled substance to an unborn child -- a crime subject to imprisonment of not less than one nor more than ten years. HB 1146.

[29] H.B. 603.

(continued...)

The federal government should discourage states from enacting laws that would punish alcohol or drug dependent women who continue their pregnancies.

The federal government should discourage state prosecutions by prohibiting hospitals from releasing of confidential medical information to social workers and state prosecutors.

The federal government can also discourage criminal prosecutions by prohibiting the release of confidential medical

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10/ (...continued)

10/ H.B. 9320 would have expanded the definition of manslaughter to include death of a child resulting form ingestion of drugs by a pregnant woman.

information by hospital to social workers and state prosecutors. Currently, hospitals in many states are mandated to report positive toxicologies of newborns to social service agencies; the report and subsequent investigation can trigger child neglect proceedings or even criminal action.

Recently, Oklahoma enacted a law that requires mandatory reporting to social services; if they find evidence of alcohol or drug use, it is authorized to provide that information to district attorneys.[11] Minnesota has amended its criminal code to mandate reporting of pregnant women who use drugs, the testing of some pregnant women for the presence of drugs, and the testing of newborns for drugs with results reported to Department of Health.[12] Failure to report may be a misdemeanor. Utah now requires medical personnel to report women whose child is born with fetal alcohol syndrome or drug dependency.[13]

These reporting laws harm poor women and women of color the most. In one recent study of Pinnellas County, Florida, for example, conducted by the National Association for Perinatal Addiction Research and Education, found that African-American women were ten times more likely to be reported to child abuse authorities than were white women even though white women were more likely to have used drugs prior to their first visit to the doctor.[14] Researchers surveyed five public health clinics from January 1 through June 30, 1989, testing a total of 715 women, 335 who were in private care. They found that 14.8 percent of all the women tested positive for alcohol, marijuana, cocaine and/or opiates, with white women 1.09 times more likely to have used alcohol or drugs prior to their first visit to the doctor. Yet, of the 133 pregnant women reported to county health authorities as substance abusers, 85 were African-American and only 45 were white. While we need to undertake similiar studies in other geographic areas, there is no reason to believe that Pinnellas County, Florida is not representative of reporting practices throughout the country.

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[11] Okla. Stat. Ann. Tit. 21, §846 (West 1989).

[12] 1989 Miss. Sess. Law Serv. Ch. 290, Art. 5 (West).

[13] Utah Code Ann. § 62A-4-504 (1989).

Morover, it appears from anecdotal evidence that women in government-subsidized facilities are routinely tested for drug use while women who can afford private health care are not tested. Women who cannot afford prenatal care may be labelled "high risk" and tested without their consent, even if their failure to obtain care is the result of poverty. Similarly, hospital practices may vary from area to area. Without standards, hospitals deciding who to report to social services or county attorneys may be improperly influenced by race and class.[15]

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[14] *See* National Association for Perinatal Addiction Research and Education (NAPARE) press release, 9/18/89.

[15] In *In re Noah D.*, Super. Ct. No. 150835 (Sup. Ct. 1989), for example, one woman was subjected to drug testing only because she had not secured prenatal care in the immediate area.

Constitutional liberty and privacy guarantees, as well as privacy statutes in some states, however, should prohibit hospitals from revealing patients' medical histories to county prosecutors or social service agencies.[16] The patients' privacy right, defined by the Supreme Court in *Whalen v. Roe* as "their interest in the nondisclosure of private information and also their interest in making important decisions independently,"[17] encompasses a patient's right to non-disclosure of his or her medical history.[18] Medical records are ordinarily entitled to a high degree of protection, and courts have upheld the sanctity of the doctor-patient relationship in the face of threats posed by reporting requirements.[19]

No compelling state interest can reasonably support disclosure of drug tests to the police under any circumstances, or to welfare agencies absent a more searching review of parental fitness. The state's interest in protecting potential life is limited and not served by mandatory reporting requirements. Roe v. Wade, 410 U.S. 113 (1973). Moreover, the state cannot have any legitimate interest in obtaining the information for the purpose of punishing pregnant women for their status as addicts.[40]

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[16] Unfortunately, courts are not following the law. In *In re Troy D.*, 263 Cal. Rptr. 869, 872 (Cal. App. 4th Dist. 1989), for example, the court rejected plaintiff's argument that the hospital had violated the California Confidentiality of Medical Information Act by releasing her medical records. The court did not see any important public policy served by preventing disclosure of the newborn's records.

[17] *Whalen v. Roe*, 429 U.S. 589, 600 (1977).

[18] *See also* *United States v. Westinghouse Electric Corp.*, 638 F.2d 570 (3rd Cir. 1980)(medical files); *Hawaii Psychiatric SOciety v. Ariyoshi*, 481 F. Supp. 1028, 1039 (D. Haw. 1979).

[19] *See* *Thornburgh v. American College of Obstetrics and Gynecologists*, 476 U.S. 747 (1986), later proceeding, *American College of Obstetricians and Gynecologists, Pennsylvania Section v. Thornburgh*, 656 F. Spup. 879 (E.D. Pa. 1987)(striking down statutory provisions requiring reporting of information about women obtaining abortions); *Jones v. Superior Court*, 119 Cal. App.3d 534, 174 Cal. Rptr. 148 (1981).

The federal government should stop the needless breakup of families

The federal government should help prevent families from needlessly being broken up. The American Civil Liberties Union survey found that many states are modifying civil child abuse statutes to provide for automatic removal of a child from its parents upon the showing of a positive toxicology of the newborn or any evidence of drug use during pregnancy. For example, Illinois,[41] Indiana,[42] Minnesota,[43] Nevada,[44] Florida,[45] and Oklahoma[46] have already amended their definition of "neglect" to include infants born with controlled substances in their system.

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[40] Robinson v. California, 370 U.S. 660 (1962).

[41] H.B. 2262; 1989 Ill. Legis. Serv. P.A. 86-275 (West).

[42] Ind. Code. Ann. § 31-6-4-3.1 (Burns 1987).

[43] 1989 Minn. Sess. Law Serv. Ch. 290, Art. 5 (West).

[44] Nev. Rev. Stat. Ann § 432B.330 (Mitchie 1989)(expanding definition of child in need of protection if suffering from FAS. District Attorney represents any child in need of protection in family court proceedings.)

[45] Fla. Stat. Ann. §415.503(7).

[46] Okla. Stat. Ann. Tit.10, § 1101 (West 1989).

Simiilar bills are pending in Arizona,[47] Deleware,[48] and Missouri.[49]

This trend raises serious civil liberties and health problems. A positive toxicology indicates only that a drug was ingested within the last twenty-four to seventy-two hours. It does not distinguish between the one time user and an addict. One can only speculate as to how many "good" parents occassional used marijuana or drank a beer prior to the birth of their child. Moreover, false positives in drug tests are quite common and the prevalence is magnified by human error. Even a positive test result does not predict future harm to the child and therefore, cannot alone be evidence that a child is in "imminent danger," the condition necessary in most states to justify removal of the child from the parent.[50] Moreover, use of a positive toxicology to trigger removal is contrary to laws that mandate that preventive services be provided prior to removal in order to keep the family together.

Positive toxicologies resulting from samples taken of newborns at birth should be used for medical intervention only.

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[47] H.B. 2690.

[48] H.B. 416.

[49] S.B. 756.

[50] See N.Y. Fam. Ct. Act §1012 et seq. (New York). The "imminent danger" standard evolved in the early 1970s as a response to imprecise language that focused primarily on parental conduct, thus permitting intervention based upon community values without consideration of the harm to the child. As a result, children were often taken away from adequate homes because they were reared in ways that conflicted with majoritarian notions of child-rearing.

The positive toxicology should not be a basis for removal without additional information or proof of parental unfitness. Prior to declaring a parent unfit, social service agencies should consider a broad range of environmental factors relating to a parent's ability to care for a child and they should assess the entire home environment. Anything less than a thorough evaluation of the family may cause its unnecessary dissolution.

When a positive toxicology is sufficient to prove neglect, child welfare officials may not even visit a home to assess its suitability for an infant. In one ACLU case in Nevada, for example, social workers removed a newborn from her mother's care solely based on their belief that the test results were a sufficient indication of fetal alcohol syndrome. Social workers never visited the home or attempted to obtain an opinion from someone trained in diagnosing fetal alcohol syndrome. Three months later, and after considerable trauma for the mother, the court ordered the baby's return when the social workers failed to prove that the child suffered from fetal alcohol syndrome.

The acute shortage of foster care, particularly in major urban areas, must also be considered when deciding whether to separate children from parents. One survey of eighteen public and private hospitals in fifteen cities, conducted by the staff of this Committee, found that eight of the eighteen hospitals reported that drug exposed newborns, medically cleared for discharge, had to remain in the hospital for various non-medical reasons, including lack of available and appropriate foster care or delayed protective service evaluation.[51] One hospital in Miami specifically attributed the high number of babies forced to remain in the hospital for up to a month to a new state law that placed all drug-exposed newborns under state custody.[52] In another study, a pilot program in Los Angeles reported that the thirteen children in its program who had been exposed to drugs in utero were placed in a total of 35 foster homes before reaching the age of three.[53] These studies suggest that, in the best interests of the children, positive test results should not trigger presumptions of neglect invoking state child protective services without a more probing review of parental fitness.

The federal government should increase appropriations to treatment programs for alcohol and drug dependent women and their children

The federal government should increase appropriations to the states to assist in the establishment of new programs and to support existing programs that provide the range of treatment services, such as residential facilities and child care, necessary to help pregnant alcoholic and drug dependent women and their children recover.

One program located in Chicago, Illinois estimated that in order to treat, annually, 150 pregnant or post partum women in their residential facilities, 200 women in their detoxification program, and another 250 in their halfway house, intensive outpatient and continuing care program would cost, in its first year, $670,000 - 700,000.[54] The second year budget is estimated at $2.8 -3.0 million.[55] The program would include twelve beds for the children of clients, eight beds for persons infected with AIDS, and other services including job training, transportation, and comprehensive family planning.[56]

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[51] Milller, G., "Addicted Infants and their Mothers," Zero to Three (National Center for Clinical Infant Programs, Vol. IX, No. 5, June 1989 at 21.

[52] Id.

[53] cite

If this program is any indication of the costs entailed in providing this range of services, all of which are integral to successful treatment, current state allocations are far from adequate. For example, a bill pending in Connecticut would require the state alcohol and drug abuse commission to implement treatment programs for drug dependent women that would offer a comprehensive range of services but the bill allocates only $375,000 in funding for the program.[57] Another bill pending in New York would allocate $200,000 for a demonstration project for drug dependent pregnant women.[58] While demonstration projects are necessary and laudable, they are not enough. We need adequate and comprehensive treatment to all those in need.[59]

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[54] The ABA Center on Children and the Law: Drug Exposed Infants and their Families: Coordinating Responses of the Legal, Medical and Child Protection System (1990) at 140-141.

[55] Id.

[56] Id.

[57] S.B. 197. Legislators in Maine attempted to appropriate $175,000 for the first year of a three year pilot substance abuse halfway house for pregnant women and mothers with young children but even that attempt was unsuccessful. H.B. 1647.

[58] H.B. 9602.

Conclusion

Addicts require habilitation, not punishment. The federal government should take the initiative on this issue and prohibit the discrimination against alcohol and drug dependent pregnant women in treatment programs and the punishment of women by punitive state laws. In addition, the government should increase the appropriations to local treatment programs to ensure that alcohol and drug dependent pregnant women can obtain comprehensive care during their pregnancy.

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[59] A recent survey by the National Association of State Alcohol and Drug Abuse Directors found that in 41 states and the District of Columbia a total of 1,400,000 persons per year are receiving alcohol and drug treatment. National Association of State Alcohol and Drug Abuse Directors, Treatment Works: The Tragic Cost of Undervaluing Treatment in the Drug War (March 1990) at 32. There is still an unmet need for an additional 10,600,000 slots. *Id.* In 44 states and the District of Columbia, an estimated 67,000 persons are on treatment waiting lists. *Id.* Approximately one-half of those have been waiting for at least thirty days. *Id.* For those who seek residential care, the nationwide estimate of average number of days between request and admission is 45 days. *Id.*

APPENDIX A

STATE BY STATE CASE SUMMARY OF CRIMINAL PROSECUTIONS AGAINST PREGNANT WOMEN

ALASKA

State of Alaska v. Grubbs, No. 4FA S89 415 Criminal (Sup. Ct. Aug 25, 1989). In Fairbanks, Alaska, a woman who allegedly used cocaine during her pregnancy was sentenced in August, 1989, to six months in jail and five years probation for criminally negligent homicide in the death of her two week-old son. An autopsy performed on the baby found that the infant died from a heart attack caused by maternal cocaine use before his birth. Geralyne Grubbs, a 23 year-old white woman, was originally charged with manslaughter but pled no contest to the lesser charge. Grubbs' attorney described Grubbs herself as the victim, whose boyfriend beat her, forced her to work as an exotic dancer, and supplied her with drugs.

CALIFORNIA

Reyes v. Superior Court, 75 Cal.App.3d 214 (Ct. App. 1977). In San Bernardino, California, a Latina woman alleged to have used heroin gave birth to twin boys who were both allegedly addicted. She was subsequently prosecuted under the criminal child endangerment statute, which carries a maximum sentence of ten years in prison. The action was dismissed by the appeals court which held that the statute was not intended to apply to prenatal conduct.

State of California v. Stewart, No. M508197 (Municipal Court, County of San Diego, Feb. 26, 1987). In 1986, Pamela Rae Stewart was arrested under a criminal child support statute and charged with "failing to follow her doctor's advice to stay off her feet, to refrain from sexual intercourse, refrain from taking street drugs, and seek immediate medical attention, if she experienced difficulties with the pregnancy." Stewart is poor, white, and a victim of battering. Among the charges levelled against her, the only illegal act alleged was the use of "street drugs," based on findings of a substance in Stewart's blood that could have been caused by an over-the-counter antihistamine. The prosecutors later admitted that illegal drug use was not a significant issue in the case.

The San Diego Municipal Court dismissed the charges after defendant's counsel brought a demurrer and motion to dismiss. The court found that California's criminal child support statute was not intended to apply to the actions of a pregnant woman and does not create a legal duty of care owed by a pregnant woman to her fetus.

CONNECTICUT

State of Connecticut v. Baez, No. CR089-010-4414 (Sup. Ct. of Middletown filed July 31, 1989). Nellie Baez, a 20 year-old Latina woman, allegedly swallowed a quarter ounce of cocaine as police moved in to arrest her last July. Baez was subsequently charged with drug possession, tampering with evidence, and risk of injury to a child; police indicated that the charges would be elevated to manslaughter if the fetus died. The possession and child endangerment charges were later dropped and Baez was sentenced to one year in prison for tampering with evidence.

DISTRICT OF COLUMBIA

In United States v. Vaughn, No. F-2172-88B (Super. Ct. of D.C., August 23, 1988), an African-American woman who pled guilty to a charge of second degree theft was given a prison term, rather than the usual sentence of probation, when the judge learned she was seven months pregnant. Suspecting that Brenda Vaughn used cocaine, Judge Peter Wolf ordered a drug test in connection with the sentencing proceeding. The judge was "horrified" to learn that she tested positive for cocaine, and explicitly said that he was sentencing Vaughn to "a long enough term in jail to be sure she would not be released until her pregnancy was concluded." There was no trial or conviction on the allegations of illegal drug use.

In an opinion explaining his decision to impose a prison term, Judge Wolf commented that, after the sentence was initially handed down, "many of [his] colleagues reported . . . having similarly sentenced or otherwise incarcerated pregnant drug abusers . . . . [W]hile Ms. Vaughn's case may be the first to have achieved publicity, she is not the first to have been given similar treatment."

FLORIDA

State of Florida v. Jerez, No. K89-16257 (Cir./County Ct. of Monroe County, Fla., warrant issued Jan. 11, 1990). Prosecutors in Monroe County have issued an arrest warrant for a 24 year-old African-American woman charged with child abuse for allegedly using cocaine during her pregnancy. The child abuse charge carries a maximum penalty of five years in prison. Similar charges brought elsewhere in the state have been dismissed because of the 1984 appeals court ruling that a fetus is not a person under Florida law. The prosecutor believes this case is distinguishable because the baby tested positive for cocaine.

State of Florida v. Black, No. 89-5325 (Cir. Ct. for Escambia County Jan. 3, 1990). A Pensacola, Florida, woman has been sentenced to 18 months in prison and 3 years probation for allegedly passing cocaine to her baby through the umbilical cord. Police claim that Beverly Black, a 32 year-old African-American woman, admitted to having snorted cocaine twice during her pregnancy in efforts to induce labor. Black, who pled no contest, is the first woman to have been imprisoned in Florida under these charges.

Since Black's arrest five more women in Escambia County have been arrested on similar charges. All are African-American women with low incomes. Frances Arlene Nelson, 28, was initially charged when she gave birth to a cocaine-exposed baby in November, 1989. Charges against Nelson have since been dropped. The attorney for Ethel Carter, 29, has moved to dismiss the charges. State of Florida v. Carter, No. 89-6274-D (Cir. Ct. for Escambia County filed Nov. 20, 1989). Prosecutions are pending against Sheila Dawson, 25, and Rhonda Maxwell, 24. Denise Lee, 25, is currently in jail awaiting trial.

State of Florida v. Gethers, No. 89-4454 CF10A (Cir. Ct. for Broward County, Fla., Nov. 6, 1989). Judge Robert B. Carney dismissed criminal charges brought against a woman who allegedly used drugs during her pregnancy. Cassandra Gethers, a 23 year-old African-American woman, was arrested last February after she and her daughter tested positive for cocaine. In November, 1989, the court ruled that the fetus was not a legal person for purposes of the child abuse statute.

State of Florida v. Hudson, No. K88-3435-CFA (Fla. Cir. Ct. July 26, 1989). Toni Hudson, a 30 year-old African-American woman, was charged with possession, distribution to a minor, and child endangerment when she gave birth to a baby with cocaine in its blood stream. Hudson pled guilty to the possession charge and the distribution and endangerment charges were dropped. She was sentenced to 150 days in jail, five years probation, and a $225 fine.

State of Florida v. Johnson, No. E89-890-CFA (Fla. Cir. Ct. July 13, 1989), appeal docketed, No. 89-1765 (Fla. Dist. Ct. App. Aug. 31, 1989). In Florida, Jennifer Johnson, a 23 year-old African-American woman, was found guilty on two counts of delivery of a controlled substance to a minor and sentenced to 15 years probation. Johnson is the first woman to be convicted under a drug trafficking statute for delivering drugs to her infant through the umbilical cord. Both of the children, who tested positive for cocaine at birth, are healthy. Under the terms of her probation, Johnson is required to spend at least one year in a residential drug treatment program, during which time she is subject to random drug testing. She must perform 200 hours of community service, must enter an intense prenatal program if she becomes pregnant again, and is forbidden to use drugs or alcohol, go to bars, or associate with people who use drugs or alcohol - for 15 years. The court found Johnson not guilty of child abuse due to lack of evidence.

GEORGIA

State of Georgia v. Coney, No. 14/403-404 (Super. Ct. of Crisp County, filed Nov. 6, 1989). Doris Coney, a 21 year-old African-American woman in Cordile, Georgia, has been indicted for distribution of cocaine to her fetus because of her alleged drug use during pregnancy.

ILLINOIS

People of the State of Illinois v. Green, No. 88-CM-8256 (Cir. Ct. filed May 8, 1989). In Rockford, Illinois, the mother of a baby whose death was linked to her alleged cocaine use while pregnant was arrested on charges of involuntary manslaughter and delivery of a controlled substance to a minor. Melanie Green, a 24 year-old African-American woman, was the first woman in the country to be charged with manslaughter for the death of a child allegedly resulting from drug use during pregnancy. If convicted, Green could have faced a five year prison term for the manslaughter charge and 14 years for delivery. The charges were later dropped, however, after a grand jury refused to indict her.

INDIANA

State of Indiana v. Yurchak, No. 64D01-8901-CF-181B (Porter County Super. Court filed Oct. 2, 1989). Brenda Yurchak, a 28 year-old Portage, Indiana woman, was charged with possession of cocaine based on findings that her baby was born addicted to cocaine. Yurchak was arrested and released on a $2500 bond. Hospital officials said they followed procedures of the new state law that requires notification if a newborn shows drug or alcohol addiction.

MASSACHUSETTS

Commonwealth of Mass. v. Levey, No. 89-2725-2729 (Super. Ct. of Mass. Dec. 4, 1989). In Waltham, Massachusetts, a prosecutor charged Elizabeth Levey with motor vehicle homicide when she miscarried at eight months and two weeks of pregnancy as a result of her alleged drunk driving. Levey is poor, white, and 27 years old. She ultimately pled guilty to reduced charges of driving while intoxicated. The court ordered her to attend a 14 day treatment program and suspended her license for five years.

Commonwealth of Mass. v. Pellegrini, No. 87970 (Super. Ct. of Mass. filed Aug. 21, 1989). Josephine Pellegrini, a 23 year-old, poor, white woman from Brockton, is the first woman in Massachusetts to be charged under the state's drug trafficking statute for "distributing" cocaine to her fetus after her infant tested positive for cocaine. The charge carries a minimum three-year state prison sentence. Her family and friends describe Pellegrini as "a battered woman who was terrified of her live-in boyfriend, the father of her three children." The Massachusetts ACLU and the ACLU are filing an amicus brief in the case, which should go to trial in April.

MICHIGAN

People of the State of Michigan v. Hardy, No. 89-2931-FY (60th Dist. Ct. for Muskegon County filed Dec. 5, 1989). In Michigan, a 23 year-old African-American woman on welfare was charged with delivery of a controlled substance and child abuse after her newborn child tested positive for cocaine. The mother, Kimberly Hardy, is currently awaiting trial; since the arrest, all three of her children have been placed in foster care. The Michigan ACLU is representing Kimberly Hardy and has sought to have the charges dismissed.

People of the State of Michigan v. Cox, No. 9053545FH (Cir. Ct. for Jackson County filed Jan. 30, 1990). In Michigan, Cheryl Cox is being prosecuted for delivery of cocaine to her fetus. Cox is a 26 year-old African-American woman. The prosecutor is arguing that the fetus was a "person" under the statute and that the alleged delivery was ongoing. A preliminary examination was held in the district court on January 12, 1990. The charges of child abuse and delivery of drugs during pregnancy were dropped, but the prosecutor held over the charge that delivery occurred during the seconds after birth before the umbilical cord was severed. Pretrial in the circuit court is currently set for April 24, 1990.

NEVADA

State of Nevada v. Bloxham, No. RJC-36887 (Reno Justice Court filed Feb. 2, 1990); State of Nevada v. Peters, No. 90-241 (Sparks Justice Court filed Feb. 2, 1990). In Washoe County, three women have been charged with child abuse after giving birth to infants who tested positive for drugs. Arrest warrants have been issued for the first two women arrested, Regina Mae Bloxham, who is white, and Sharon L. Peters; Bloxham has agreed to cooperate with the police and plans to turn herself in, according to officials. The third woman was charged in February, 1990, with use of a controlled substance and child abuse.

NORTH CAROLINA

State of North Carolina v. Inzar, No. 90 CRS 6960 6961 (Sup. Ct. of Robeson County, filed April 16, 1990). In Lumberton, a 2 year-old woman who allegedly smoked crack cocaine the day before she gave birth to a brain-damaged child was recently indicted on charges of assault with a deadly weapon and distributing cocaine to a minor.

OHIO

Cox v. Court of Common Pleas, No. 88AP 856 (Ct. App. for Franklin County Dec. 13, 1988). In Ohio, Franklin County prosecutors persuaded a juvenile court to issue an order placing Janet Cox, a white woman in her seventh month of pregnancy, in "a secure drug treatment facility" to protect the fetus from Cox's alleged drug use. The Court of Appeals overturned the order, holding that the trial court had no jurisdiction over an adult woman for the purpose of controlling her conduct during her pregnancy.

State of Ohio v. Andrews, No. JU 68459 (Ct. C.P. of Stark County, Ohio, June 19, 1989). Tina Andrews, an African-American woman from Stark County, Ohio, was charged with child endangerment for her alleged cocaine use during her pregnancy. The trial court held that Ohio's child endangerment statute applies only to children born at the time the endangering activity occurs and dismissed the charges.

State of Ohio v. Gray, No. CR88-7406 (Ct. C.P. of Lucas County, Ohio, July 13, 1989). In Ohio, Tammy Gray was charged with child endangerment for her alleged cocaine use during her pregnancy. Gray is a 27 year-old African-American woman. Relying on *Reyes*, the trial court refused to extend the Ohio child endangerment statute to include a fetus and dismissed the charges against Gray. The state is appealing the trial court decision.

SOUTH CAROLINA

Since August, 1989, eighteen women in South Carolina who allegedly took drugs during their pregnancy have been charged with either criminal neglect of a child or distribution of drugs to a minor. Seventeen of the eighteen women are African-American; one is white. Three other Charleston women, while not facing criminal charges, have had their children taken away from them through neglect proceedings in Family Court. Many of the infants did not test positive for drugs. Sources report that the hospital's new policy of reporting positive drug screens to the police has deterred some area women from seeking hospital care for their pregnancy.

In Charleston, ten women have been charged with criminal neglect or distribution. One Charleston case involves an 18 year-old African-American woman who was arrested in the seventh month of her pregnancy. On the basis of a positive drug test she was charged with possession and distribution and placed under house arrest for the duration of her pregnancy. The baby was born healthy and tested negative for cocaine. The magistrate who first heard the case dismissed the charges but the state has indicated that it will continue to seek an indictment.

In Greenville, eight women have been arrested and charged with criminal neglect of a child. Judge Hubert Long sentenced one 20 year-old woman to three-and-a-half years in prison, suspended to five years probation, on child neglect charges because of her alleged cocaine use during pregnancy. In a similar case, a 15 year-old mother and her parents have all been charged with criminal neglect based on the positive drug test of the woman's five-day-old baby. The grandparents in that case are charged with failing to provide proper care for their daughter and the daughter's child.

SOUTH DAKOTA

State of South Dakota v. Christensen, No. CRI. 90- (S.D. Cir. Ct. Mar. 12, 1990). A Native American woman in South Dakota was recently sentenced to six months in jail for giving birth to a baby with cocaine in its bloodstream. Roberta Christensen, 28, gave birth prematurely last August after being severely beaten by her boyfriend and allegedly using cocaine. When hospital tests indicated that Christensen's infant had traces of cocaine in its system, the baby was taken from her and she voluntarily entered a treatment program. Christensen was extremely successful and had been drug and alcohol free for seven months when she was arrested in March, 1990, and charged with contributing to the dependency of a minor and ingestion of a toxic substance. On the advice of her attorney Christensen pled guilty to the ingestion charge.

Magistrate Judge Joseph Neiles, indicating that he wanted to "send a strong message" to other pregnant addicts, sentenced Christensen to the maximum possible sentence despite evidence of her rehabilitation. The judge emphasized that Christensen had made one unsuccessful attempt to complete a treatment program before satisfactorily completing a second program, and also noted that the defendant had "from time to time been uncooperative" with social service workers. Judge Neiles has also denied Christensen visitation with her children, saying that he didn't "really intend to get in the way of getting you back together with your child if that is appropriate; but . . . I am not convinced that that is appropriate." Christensen's child is still in foster care. Her attorneys plan to appeal the visitation ruling.

TEXAS

State of Texas v. Rodden, No. 0373625R (Dist. Ct. for Tarrant County filed June 1, 1989). Radeana Love Rodden, a 26 year-old white woman in Tarrant County, Texas, was indicted on a felony charge for injury to a child when her baby was born allegedly addicted to cocaine. The charges were dismissed when officials learned that, since Rodden was taking medically prescribed methadone, it was unclear whether the infant's withdrawal was caused by legal or illegal drugs.

WYOMING

State of Wyoming v. Pfannenstiel, No. 1-90-8CR (County Ct. of Laramie, WY, complaint filed Jan. 5, 1990). In Albany County, Wyoming, a pregnant woman who entered a hospital for treatment for injuries inflicted by her abusive husband was tested for alcohol, arrested, jailed, and charged with criminal child abuse for endangering her fetus. Dianne Pfannenstiel, 29 years old, white, and the mother of two children, had been married three years to a man who abused her before she finally walked out in January. When she left, Pfannenstiel had bruises on her neck, arms, and back from her husband's beatings and she was concerned that her fetus might have been injured. Pfannenstiel was arrested while she waited in the hospital emergency room. On February 1, 1990, the court found no probable cause to continue the case.

State of Wyoming v. Osmus, 276 P.2d 469 (Wyo. 1954). Over 35 years ago, a Wyoming woman was charged with endangering the life of her fetus under the state child abuse statute. The Wyoming Supreme Court found that the statute was not intended to apply to an unborn child, and dismissed the charges.

APPENDIX B

State Survey

LEGISLATION PERTAINING TO DRUG USE DURING PREGNANCY

(* legislative session is closed for the year)

ALABAMA*	Health department has policy regarding random urine tests of pregnant women, for purposes of compiling statistics for department. legislative session 1/9-4/23.
ALASKA*	S.B. 414 proposes that pregnant alcoholics be subject to involuntary committment. Status: pending legislative session 1/8-5/7.
ARIZONA*	H.B. 2690 Omnibus Child Protection Act defined abuse as including "exposure to a controlled substance used by a mother for nonmedical purposes, as medically indicated by withdrawal symptoms in the child at birth or results of a toxicology test performed on the mother or child at delivery...." Status: this provision was removed in the Human Resources Committee.
New Law	H.B. 2249 expands coverage for pregnant women and infants to 133% of the federal poverty level. Amended to set up substance abuse demonstration program for TXIX eligible pregnant women, before or after delivery, who are diagnosed as having drug dependency problems, but does not allocate any new funds for the program. legislative session 1/8-late April.
ARKANSAS	
New Law	FAS signs legislation passed. no regular session.

CALIFORNIA	S.B. 2669 provides for prenatal and postnatal services; requires follow-up home visits where there is a positive toxicology within 72 hours; no reporting to child welfare services of a positive toxicology required unless there is subsequent evidence of abuse; limits use of information for health care purposes only; county agency plan shall include development of a treatment system available upon demand to the extent feasible; pregnant women shall receive priority for services; recognizes that urine testing does not provide information that is adequate to determine level of risk to newborn or ablity of mother to provide care for the child or data that would be helpful for early intervention; requires county agency to develop a plan which includes development of a continuum of health care services (introduced March 1, 1990). Status: Placed on Suspension Calendar and will be reconsidered in June. legislative session 1/2-8/31.
COLORADO*	H.B. 1170 provides that a physician must report a woman suspected of drug use to social services who must then charge her with child abuse upon the birth of the child. Status: Pending in Senate Appropriations Committee, passed in House. legislative session 1/10-5/9.
CONNECTICUT*	S.B. 197 provides that the state alcohol and drug abuse commission is required to develop and implement treatment programs for drug dependent women; each program shall offer comprehensive services including education, case management, hospital care in coordination with obstetrical services, pediatric care, child care for other siblings, parenting classes, access to WIC and other services; establishes a task force to review current state policies; provides for $376,000 for services; hospitals shall provide pregnant patients or women who gave birth and show symptoms of substance use with referrals to entitlement programs, treatment, and appropriate community based support services; department of income maintenance shall collect data on drug dependent women

and their children receiving medical assistance and report to joint standing committees; statistical information shall be maintained on a confidential basis
Status: Pending in House.

New Law 1989 Conn. Acts, P.A. 390 appropriates funds to establish and maintain treatment programs for low-income pregnant women and mothers.

legislative session 2/7-5/9.

DELAWARE H.B. 416 amends the definition of child abuse to include children born with controlled substance in their system; Provides child protection services with authority to investigate parents and child for purposes of treatment. Status: Not likely to be voted on before end of session.

H.B. 571 requires any person required to report under Subchapter 1 to report any woman suspected of using a controlled substance during pregnancy to the Bureau of Personal and Family Health; the Bureau "shall" offer services (which are not clearly specified) where appropriate; persons reporting are granted immunity; doctors are required to administer toxicology tests to any woman suspected of drug use during pregnancy and to the newborn and report the results; positive tests must be confirmed by a licensed laboratory in accordance with state and federal standards. Status: Not likely to be voted on before end of session.

legislative session 1/9-6/30.

DIST. OF COLUMBIA Nothing passed or pending.

legislative session all year.

FLORIDA

H.B. 2921 provides for the termination of parental rights in the event 1) mother tests positive for controlled substance; 2) is observed using a controlled substance; 3) newborn tests positive; requires doctors to administer toxicology tests to all newborns (383.141(1)) if there is "reasonable ground" to believe the mother used a controlled substance during pregnancy. Doctor is required to report positive tests; doctors are immune from civil liability; Department of Health and Rehabilitative Services is required to adopt rules establishing criteria for testing, and to conduct an immediate investigation of the needs of the child's parent(s) and offer services (which are specified by not mandated) to address those needs if the department determines that the child or parent may benefit from such services or when the child is born dependent on a controlled substance or the report alleges prenatal exposure to a controlled substance based on a toxicology test or where there are reasonable grounds to believe that the child is exposed to drugs and as a result the child exhibits certain developmental problems. If a parent refuses services the department may file a dependency petition.

The department shall notify the state attorney or a law enforcement agency of any drug use of a parent if a child dies of abuse or neglect or is a victim of aggravated child abuse. Status: Pending in Appropriations Committee.

H.B. 2297 would create a Alcohol and Drug Abuse Treatment, Intervention and Prevention Trust Fund to fund treatment, intervention, and prevention of alcohol and drug abuse. Status: Pending in Finance and Tax Committee.

New Law

1989 Fla. Laws Chap. 345 establishes the powers and duties of guardian advocates for drug-dependent newborns who may provide consent for medical treatment and advocate for child.

New Law

1988 Fla. Stat. Ann. §415.503 (Supp. 1988) provides that "harm" to a child's health or welfare may occur when a newborn infant is born with a physical dependency on a controlled substance; no parent shall be subject to criminal investigation solely on the basis of an infant's drug dependency.

legislative session 4/3-6/1.

GEORGIA*

H.B. 1146 provided that any person who uses a controlled substance or dangerous drug while pregnant, and who as a result gives birth to a child who "tests positive for addiction," shall be guilty of the offense of distributing a controlled substance to an unborn child, a felony, subject to imprisonment for not less than one nor more than ten years. If it is the woman's first conviction, the judge may probate the sentence and may require the defendant to undergo a mandatory period of treatment. Upon a second conviction, the defendant shall be punished by imprisonment for not less than two years nor more than twenty. Status: DEFEATED.

legislative session 1/8- mid-march.

HAWAII

H.B. 3219 provides that upon giving birth to a second drug exposed child, family court action would be triggered and the mother could lose custody of all her children; provides that children have a right to be born drug free and finds that it is the responsibility of all parents to protect that right by not using illegal drugs during pregnancy. Status: Defeated.

IDAHO*

Nothing passed or pending.

legislative session 1/8 - late March.

ILLINOIS

S.B. 1337 provides for alcohol use during pregnancy warning signs. Status: Pending in Senate.

S.B. 1685 establishes a Women's Office of Treatment to study and make recommendations. Status: Pending in Rules Committee.

New Law 1989 Ill. Laws, P.A. 86-275 expands definition of neglect to include newborns whose blood or urine contains any amount of a controlled substance.

New Law	1989 Ill. Laws, P.A. 86-877 appropriates funds for the development of a model program for the care and treatment of addicted pregnant women, mothers, and their children.
New Law	1989 Ill. Laws, P.A. 86-878 requires the department of health to conduct a statewide education program to inform pregnant women of the medical consequences of substance abuse.
	legislative session 1/10-6/30.
INDIANA*	Nothing pending.
New Law	Ind. Code Ann. §31-6-4-3.1 (Burns 1987) defines a child in need of services as one born with fetal alcohol syndrome or an addiction to a controlled substance.
	legislative session 1/8 - mid-March.
IOWA*	
New Law	H.B. 2564 authorizes drug testing of newborns if physician suspects mother of drug use; prohibits criminal action against the mother; requires more than a positive toxicology as evidence of child abuse; establishes a task force; allocates $125,000 for a demonstration project for treatment of infants, mothers with drug dependency problems and women of childbearing age.
	legislative session 1/8-late April.
KANSAS*	Nothing passed or pending.
	legislative session 1/8-4/7.
KENTUCKY*	
New Law	H.B. 159 establishes a task force.
	legislative session 1/2-mid-April
LOUISIANA	H.B. 603 would make drug use during pregnancy a felony. Status: pending.
	legislative session 4/16-7/9.

MAINE*

H.B. 1647 would allocate $175,000 for one year for a three year pilot program setting up a halfway house for pregnant women and their children. Status: DEFEATED.

legislative session 1/3-4/18.

MARYLAND*

Nothing passed or pending.

legislative session 1/10-4/9.

MASSACHUSETTS

Nothing passed or pending.

Proposed DSS policy - intervention if pregnant woman is suspected of using drugs. Essentially assumes that any woman who has history of drug use is a suspect for current use.

New Law

Mass. Gen. Laws. Ann. ch. 119, §51A (West Supp. 1988) defines neglect to include child who is determined to be physically dependent upon an addictive drug at birth.

legislative session 1/3-all year.

MICHIGAN

Nothing passed or pending.

legislative session 1/10 - all year. (Convenes every 2 years and remains in session throughout [except for short seasonal vacations].)

MINNESOTA*

New Law

1989 Minn. Laws Chap. 2390 omnibus child protection bill provides for use of posters warning of the dangers of alcohol use during pregnancy; expands definition of neglect to include prenatal exposure to a controlled substance as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother or child, or medical effects or developmental delays; those suspecting "neglect" "shall" report the information to the local welfare agency, police department or county sheriff; grants immunity to those who report; reports

	may be made available to social service or law enforcement agencies of other states; provides immunity from liability for testing; provides that the local welfare agency shall conduct an immediate investigation and offer services which may include referral for assessment, treatment and prenatal care; "the local welfare agency may also take any appropriate action under chapter 253B, including seeking emergency admission under section 253B.05. legislative session 2/12-late April7.
MISSISSIPPI*	Nothing passed or pending. legislative session 1/2-4/1.
MISSOURI*	S.B. 756 defines neglect to include prenatal exposure to drugs as evidenced by withdrawal or a toxicology test performed on mother or child; reports of neglect shall be made to the Division of Family Services who "shall" contact the appropriate law enforcement agency; the division "shall" offer services which may include, but are not limited to, a referral to treatment or prenatal care. If the pregnant woman refuses treatment, the division shall file in the probate division a petition for the appointment of a guardian; proof that prenatal drug use produced intoxiciation, disorientation, etc. shall be prima facie evidence of neglect. **Status**: In House Budget Committee legislative session 1/3-5/15.
MONTANA*	Nothing passed or pending in 1989. Legislature not in session in 1990.
NEBRASKA*	Nothing passed or pending. legislative session 1/3-April.
NEVADA*	1990 is not a legislative year.

New Law — Nev. Rev.Stat.Ann. 432B.330 (Mitchie 1989) defines child born with fetal alcohol syndrome as neglected.

NEW HAMPSHIRE*

New Law — Provides for establishment of a task force.

legislative session 1/3-early May.

NEW JERSEY — Nothing passed or pending.

legislative session 1/9-all year.

NEW MEXICO* — Nothing passed or pending.

legislative session 1/16-2/14.

NEW YORK — H.B. 7515A would amend the public health law to create up to three demonstration projects which would involve the coordination of prenatal care, primary famiy care, drug treatment, parenting and other abuse counseling services, etc., to pregnant drug dependent women. Appropriates $2,750,000 for the demonstration project. Status: Pending.

Leg. Drafting Commission Bill 12099-03-0 would prohibit the incarceration or confinement of women for drug use during pregnancy and prevent the use of positive toxicologies as evidence of neglect or abuse. Status: Pending.

H.B. 9735 would define abandoned child as one who tests positive for a controlled substance at or about birth and has been abandoned at birth by the parent(s). Status: Pending.

H.B. 9602 would establish a demonstration project for treatment services for addicted pregnant women. Allocates $200,000 to commissioner of health and director of division of substance abuse services. Program is to be administered thorugh the community health service in conjunction with a local community hospital. Status: Pending.

legislative session 1/3-July.

NORTH CAROLINA

Nothing passed or pending.

legislative session 5/21-July.

NORTH DAKOTA

Nothing passed or pending.

no regular session.

OHIO

S.B. 324 defines neglected child as one who is addicted at birth to a drug; women who use drugs and give birth to addicted infants may be charged with prenatal child abuse and a class 2 felony. The court may mandate: 1) successful completion of a drug rehabilitation program; 2) tubal ligation; 3) participate in drug rehab and be monitored for contraceptive use (if she has a lapse, then is sterilized).

If the woman does not choose any of the above, she is guilty of aggravated prenatal child neglect and may be subjected to imprisonment for up to twenty-five years and fined or required to make restitution. If convicted, or if she pleads guilty, she will be required to reimburse agencies for their investigation or prosecution. Legislature has adjourned until late fall. Status: Tabled in committee.

legislative session 1/2-all year.

OKLAHOMA

Nothing passed or pending.

legislative session 2/5-5/25.

New Law

1989 Okla. Sess. Laws, Chap. 213 authorizes the Department of Human Services to require, as part of an out-of-home placement plan, that the mother of a child born dependent on illegal drugs complete a treatment program before the child is returned to her. Also authorizes a treatment program for any other drug dependent adult living in the child's home as well as periodic testing of one or both parents.

New Law	Okla. Stat. Ann. Tit.10, §1101(4)(Supp.1989) defines "deprived child" as one born in a condition of dependence on a controlled substance and his parents is unable to and wilfully fails to provide special care.
New Law	Okla. Stat. Ann. Tit.21, §846 (West 1989) requires mandatory reporting of birth of chemically dependent child to social services. If they find evidence of abuse, the information is to be provided to district attorneys. Failure to report may be a misdemeanor.
OREGON	H.B. 2481 extends Juvenile Court jurisdiction to children born with addiction or any indication of drug use by mother are removed from mother's custody. Status: passed House DEFEATED.
	In 1991 a proposal seeking to establish treatment on demand will be introduced.
	Nothing else passed or was introduced.
PENNSYLVANIA	S.B. 575 provides for persons reqired to report child abuse to report children with fetal alcohol syndrome, neonatal abstinence or the systemic presence of a substance; prohibits criminal investigation of the birthmother; creates a registry of children born to women who used drugs or alcohol during pregnancy. Status: in House committee.
	H.B. 2330 reqires that physicians report pregnant women who are using drugs or alcohol to the Department of Health; the Department shall conduct an appropriate assessment and offer services including treatment and prenatal care; doctors must obtain the informed consent of the patient before testing except authorizes testing where obstetrical complications indicate that a patient has ingested a controlled substance between 24 weeks of gestation and delivery; provides immunity from liability to medical personnel; reqires that the test be confirmed. Status: in Committee on Health and Welfare.
	legislative session 1/2 - all year.

RHODE ISLAND*	H.B. 9320 expands definition of manslaughter to include death of a child resulting form injestion of drugs by a pregnant women. Status: DEFEATED A number of other punitive measures were introduced but were all defeated. However, the Department for Children and Families has passed regulations requiring physicians to report drug-dependent pregnant women.
New Law	H.B. 6084 (1989) establishes a special commission to study the current status of treatment programs available to drug dependent mothers and the corresponding placement options available to young children born of drug dependent mothers. legislative session 1/2-May.
SOUTH CAROLINA	Nothing passed or pending. legislative session 1/9-6/7.
SOUTH DAKOTA*	Nothing passed or pending. legislative session 1/9-early March.
TENNESSEE*	Nothing passed or pending. legislative session 1/9-mid-April.
TEXAS	Nothing passed or pending. no regular session.
UTAH*	Nothing passed or pending. legislative session 1/8-2/21.
New Law	Utah Code Ann. 62A-4-504 (1989) requires medical personnel to report when they find a child born with fetal alcohol syndrome or dependent on a controlled substance.
VERMONT*	Nothing passed or pending.

	legislative session 1/2-mid-April.
VIRGINIA*	Nothing passed or pending. legislative sesssion 1/10-3/10.
WASHINGTON*	HB 2751 provides for treatment for infants with special needs. Status: DEFEATED.
New Law	1989 Wash. Laws, Chap. 271, Part IV creates a drug enforcement and education account to provide appropriations services to drug dependent pregnant women. legislative session 1/8-3/8.
WEST VIRGINIA*	Nothing passed or pending. legislative session 1/10-3/10.
WISCONSIN*	
New Law	Act 122 - The legislature held a special session on drug-related issues; infant may be tested with parental or guardian consent; positive toxicologies must be reported; provides for provision of services. legislative session 1/23-8/17.
WYOMING*	Nothing passed or pending. legislative session 2/13-early March.
PUERTO RICO*	Nothing passed or pending. legislative session 1/8-4/30.

APPENDIX C

The following includes all states that have public accomodations laws:

Alaska Sta. §18.80.200;
Cal. Civ. Code 51, 52;
Col. Rev. Stat. §24-34-601;
Conn. Gen. Stat. §46a-63, 64;
Del. Code Ann. Tit. 6, §4504;
D.C. Code Ann. §1-2519;
Fla. Stat. §509.092, .141, 142;
Idaho Code §67-5909(5);
Ill. Rev. Stat. ch. 68 5-102, 103;
Ind. Code §22-9-1-2;
Iowa §601A.7;
Kan. Stat. Ann. §44-1009 (c)(1);
Ky. Rev. Stat. Ann. §344.130, .145;
La. Rev. Stat. Ann. §49:146;
Me. Rev. Stat. Ann. title.5, §§4951, 4952;
Md. Code. Ann. art. 49B, §5;
Mass. Gen. L. ch.272, §98;
Mich. Comp. Laws §37.2301;
Minn. Stat. §363.03(3);
Mo. Rev. Stat. §314.010;
Mont. Code Ann. §49-2-304;
Neb. Rev. Stat. §20-134;
N.H. Rev. Stat. Ann. §354-A:8(IV);
N.J. Rev. Stat. §10:5-12(f);
N.M. Stat. Ann. §28-1-7(f);
N.Y. Exec. Law §296(2);
N.D. Cent. Code §12.1-14-04, §14-02.4-14, -02.4-16.
Ohio Rev. Code Ann. §4112.02(g);
Or. Rev. Stat. §30.680;
Pa. Stat. Ann. tit. 43, §955(i);
R.I. Gen. Laws §11-24-2-3.1;
S.D. Cod. Laws Ann. §20-13-23;
Tenn. Code Ann. §4-21-111;
Utah Code Ann. §13-7-3;
Wash. Rev. Code §49.60.215;
W. Va. Code §5-11-9(f);
Wis. Stat. §942.04;
Wyo. Stat. §6-9-101.

Arizona, Oklahoma, Nevada and Vermont have statutory prohibitions against discrimination in public accomodations but gender discrimination is permissible. See Ariz. Rev. Stat. Ann. §41-1442; Nev. Rev. Stat. §651.070; Okla. Stat. tit. 25, §1402; Vt. Stat. Ann. tit. 13, §1451.

Mr. **Hastert**. If I may, I'd like to introduce Mr. Ryan as a constituent and certainly a colleague that I've known for a number of years in my experience in the General Assembly. Jim Ryan is the State's Attorney of one of my counties, DuPage County, that is approaching a million population, so it's a big responsibility.

Even more so, I'd like to introduce you to somebody who has been extremely interested and effective in the area of children and family issues. Mr. Ryan just recently authored a bill that was passed in the Illinois General Assembly, commonly known as the Cocaine Baby Bill, that was signed into law last August and effective this January. In years past, he's established programs in DuPage County for women and children and families, including the establishment of the Children's Advocacy Center for sexually abused children, which has become really a state and a national model.

His office recently established one of the most comprehensive programs for battered wives and physically abused children in Illinois. Three years ago, he established the award winning program of child support and enforcement. That's certainly something that we've talked a great deal about in this committee for DuPage County. We certainly extend to him a very, very warm welcome to this committee.

STATEMENT OF JAMES RYAN, J.D., DUPAGE COUNTY STATE'S ATTORNEY, WHEATON, IL

Mr. **Ryan**. Thank you, Chairman Miller. Thank you distinguished members of the Committee and Congressman Hastert for that very kind introduction. I want to thank you for today's invitation and for the opportunity of discussing some of the issues that are important to all of us and to participate in this important public hearing.

The most serious threat, I think, to the health, safety and welfare of every American is the continuing epidemic of drug abuse. We still, despite our efforts, have drugs in schools, neighborhoods and in the work place. The link between drugs and crime is clear and now well documented. Drugs, in fact, threaten to overwhelm our criminal justice system.

The problem of prison overcrowding is exacerbated by the number of drug admissions in Illinois and across the country. Now the latest victims in this drug epidemic are cocaine babies and other drug-exposed infants. As was indicated here earlier today, it's estimated that there are some 375,000 of these children born last year and possibly every year.

These kids are 15 times more likely to die of Sudden Infant Death Syndrome. They are born with developmental disabilities, learning disabilities and we are literally creating a generation of damaged children in this country. In Illinois, the number of reported cases of drug-exposed infants has increased dramatically over the years.

Back in 1985, the Department of Children and Family Services, which is our Welfare Protection Agency, reported 181 cases of drug-exposed infants. That figure rose to 2,175 in 1989. In 1990 through March of this year, there were 1,880 cases reported. The projected number for the rest of the year is, again, much larger. In DuPage County where I am in my second term as State's Attorney, we had 22 reported cases last year that required some court involvement. This year we have 8 cases where petitions have been filed in juvenile court.

Not long ago, my office, in collaboration with Dr. Ira Chasnoff, who is a physician at Northwestern University and an expert in perinatal care, worked together to draft a bill which would make it easier to deliver services and treatment to drug-exposed infants in Illinois. That bill was signed into law in August of last year by Governor Thompson and became effective in January of this year.

The bill makes two important changes in Illinois law. The first is that it redefines neglect under Illinois law to include any newborn that tests positive for any illegal controlled substance. So it creates a new category of neglect in Illinois in addition to environment, injurious and instances where a child isn't given proper shelter or food or clothing. There's a third category of infants that test positive for an illegal controlled substance.

The second change in the law mandates that doctors and other health care professionals report findings, positive findings to the Department of Children and Family Services. Let me pause at this juncture to tell you what the law doesn't provide for. It does not provide for mandatory drug screening. It simply says that if a doctor or health care professional happens to identify a controlled substance in the blood or urine of an infant or a newborn that that be reported to the Department of Children and Family Services.

Secondly, it does not involve the criminal prosecution of the mother. It is a proceeding in juvenile court and there are no criminal sanctions. Medical research suggests that early intervention is important to reduce the risk to these children. That was the purpose for enacting this piece of legislation.

The Department of Children and Family Services, once this report is received, is required to investigate the circumstances surrounding the evidence which comes to its attention. It has the option, of course, of contacting the State's Attorney and filing a petition in juvenile court to determine whether or not this child should be adjudicated a neglected minor under Illinois law.

In Juvenile Court, the focus of the proceedings is what is in the best interest of the minor child and how to best preserve the family. The Juvenile Court judge, if there is a finding of neglect—and under this particular statute it would be a per se situation if you can prove that there is a positive test—the court then has a number of options, including simply monitoring the child's progress and medical treatment.

The mother can voluntarily enter a drug rehab program. The range of options include, in the more extreme situations, placing the child in foster care and naming that child a ward of the court, naming the Department of Children and Family Services as the guardian of that child.

The mother, as part of the court proceedings, because she is a respondent in the action, can be required to undergo drug rehabilitation. She can be required to learn certain parenting skills, because one of the things we all have learned about cocaine babies and other drug-exposed infants is that they are often very difficult for parents to handle.

Parents need to be educated on how best to handle these children. The incidents of child abuse and families that have given birth to cocaine babies has increased. At least there is some evidence that suggests that. So parenting skills are important.

The court has the authority to order the respondent mother to undergo treatment. In cases where this child is at risk, as a condition preceding reuniting the mother with the child, the court can require drug rehabilitation. For intervention to be successful, we must have adequate treatment resources.

In Illinois, we've taken important steps to provide treatment to mothers and children, but more obviously needs to be done. That fact has been highlighted very well during today's hearing. We do need more money for treatment facilities that can accommodate mothers and children, and to provide things like job training opportunities, daycare for their children; a whole host of services that need to be provided.

To solve the problem, ultimately will require increased public education. We have to convince mothers and women that drug abuse is detrimental to their health and to the health of the fetus, and their newborn children; and in doing so, hopefully prevent this problem from ever happening. We also, as was pointed out during the hearing, have to increase the amount of training that doctors receive so they can better identify drug exposed infants.

The Congress can take a leadership role in combating the dangerous consequences of drug abuse, to women and children, by providing or helping to provide adequate funding to the states; and in doing so, we can all work together in preserving our countries greatest resource, our children. Thank you, Mr. Chairman.

[Prepared statement of James Ryan follows:]

Prepared Statement of James E. Ryan, DuPage County State's Attorney, Wheaton, IL

Testimony of James E. Ryan, State's Attorney
of DuPage County, Illinois and President of
the Illinois State's Attorney's Association,
before the Select Committee on Children,
Youth and Families of the United States House of
Representatives during the May 17, 1990
hearing entitled "Law and Policy Affecting
Addicted Women and Their Children":

I wish to thank the members of the Select Committee for inviting me to speak today. As State's Attorney for the second most populous county in Illinois for the past six years I have in many different ways addressed the multi-dimensional problems facing my community due to the epidemic use of illicit drugs. One of the most unfortunate aspects of this problem and one which harbors even more severe consequences for the future is the every day birth of children whose mothers used illegal drugs during their pregnancies.

The medical evidence indicates that a child born to a cocaine abusing mother is 15 times more likely to die of sudden infant death syndrome, and such a child is at a much greater risk of suffering health problems such as low birth weight, motor development problems, neurobehavioral deficiencies and other physical abnormalities.

When our legislation was proposed we examined the reported cases of babies born in Illinois with evidence of drug abuse by the mother and found the following numbers of reported cases:

Fiscal Year Ending 6/30

1985 - 181
1986 - 207
1987 - 530
1988 - 1,231
1989 - 2,175
(as of 3/30) 1990 - 1,880
(projected) 1990 - 2,616
(projected) 1991 - 3,144

Approximately 80 percent of these cases were from Cook County (Chicago). Thus, the statistics would strongly indicate that this is a dramatically escalating problem. It should be noted that these reported cases pre-date the present mandatory reporting requirements, therefore, the number of future cases would likely exceed this pattern of escalation.

In an effort to address this societal problem I had my office draft certain legislation in 1989. This legislation was designed to require state intervention at a point in time when steps could be undertaken to lessen the consequences to both mother and child. The legislative proposal received bipartisan sponsorship in the Illinois General Assembly and was signed by

Governor Thompson in August of last year and was effective January 1, 1990.

The legislation, which was referred to as the "Cocaine Baby" Bill, established a new category of neglected minors for cases in which a newborn tested positive for illegal drugs, thereby allowing the Department of Children and Family Services (DCFS) to intervene with services and treatment. The bill mandates health care personnel to report to DCFS any blood or urine tests which indicate the presence within the newborn of any controlled substances, or metabolities of such substances, other than those which may have been administered to the mother or newborn for legitimate medical treatment.

These neglect cases are processed under the Juvenile Court Act of Illinois, and, thus, the focus, as in all juvenile court cases, is the "best interests of the minor" and the preservation of the family. These cases are not handled as criminal matters. The Juvenile Court Act offers a full range of intervention options consistent with the aforementioned objectives. The types of intervention range from informal action by DCFS which might include voluntary treatment of the mother and monitoring of the child's medical condition to extreme cases in which formal juvenile proceedings might be undertaken to place the child in foster care.

The problem to be addressed is the consequences of the mother's drug abuse. The mother may need help in dealing with not only her own addiction but the extreme problems of parenting a child with severe medical problems as a result of her drug addiction. This approach is not designed to punish the mother, but to intervene with treatment so as to address the best interests of the child and the family as a whole.

I would fully endorse any action this Committee might take which would serve to implement this approach, not only within the State of Illinois, but throughout the United States. The underlying component of this entire approach is treatment. The Congress is in a position to provide the leadership and funding necessary to adequately implement these programs. We as representatives of the people, have an obligation to address the devastating consequences of drug abuse which could lead to a generation of damaged children.

STATEMENT OF JO ANN KAUFFMAN, M.P.H., PRESIDENT, NATIONAL ASSOCIATION FOR NATIVE AMERICAN CHILDREN OF ALCOHOLICS, WASHINGTON, DC

Ms. KAUFFMAN. Thank you for inviting me here to this hearing to testify on behalf of The National Association for Native American Children of Alcoholics. I'm the President of the Board of that organization and we were formed in 1988 and have been providing training to Indian communities around the multi-generational effect of alcoholism and substance abuse in our communities.

Before getting into the recommendations, I would like to provide some background on substance abuse in Indian communities. The Indian Health Service, which is the federal agency that has primary responsibility for health care over Indian people, cites that four out of the ten leading causes of death for Indian people are directly related to alcoholism or alcohol abuse. These include accidents, cirrhosis, suicides, and homicides.

Others among those ten leading causes of death can be indirectly related to alcoholism and substance abuse. Indian people die from alcoholism at a rate five times that of the general public. While the Indian Health Service has been able to show that infant mortality in Indian communities has been reduced, the infant mortality rate has been reduced primarily in the neonatal period of life; that is from birth to twenty-eight days.

From twenty-eight days to twelve months, infant death rates for Indian people again start to climb above the national average. This is during the time when the infant is exposed to the home environment and most vulnerable to the alcoholism and other addicted behaviors in the household.

There are a variety of theories as to why Indian people experience a much higher alcoholism rate than other people in the United States. Some believe that it is a genetic pre-disposition, other people believe that it is a learned behavior that was learned by Indian people at the initial contact with Europeans and the gifts of firewater and the rituals of drunkenness at the treaty signing.

Other people believe that it had to do with prohibition; until the 1950's Indian people could not legally purchase alcohol. Yet others believe that it is a result of the depression from poverty, and racism, and cultural loss, and relocation that contributes to Indian alcoholism.

Whichever theory you subscribe to, overlay all of these together, and you see the formula of why Indian people experience such a high rate of alcoholism.

For our youth, we have other problems as well with the introduction of cocaine into the reservation settings and other illegal drugs. We also have a history of inhalant abuse among young children who inhale anything that will get them high, from glue to gasoline to paint.

The services that are available to Indian people are very sparse. It's estimated that only two percent of all those Indian people who require substance abuse treatment are able to get substance abuse treatment.

In the 1970's the National Institute on Alcohol Abuse and Alcoholism provided some initial start-up funds for Indian alcohol programs. In 1976 the Indian Health Service absorbed these NIAAA programs under the authority of the Indian Health Care Improvement Act. But it was not until the passage of the Anti-Drug Act in 1986 and the amendments in 1988 that Indian communities really began to develop their own community based response to alcoholism and substance abuse.

Today, we are facing the difficulty of developing services specifically for Indian women. The resources I have described developed through NIAAA were basically treatment programs based on the twelve step model of Alcoholics Anonymous. A good program, but the experience was that it was mainly effective with older adult male chronic alcoholics. For Indian women, and for youths, new approaches are necessary.

Fetal Alcohol Syndrome has become a major problem in Indian communities. A recent book by best-selling author, Michael Dorris, entitled, "The Broken Cord," describes his own personal struggle raising his adopted son who is diagnosed with Fetal Alcohol Syndrome.

Chairman MILLER. I'm sorry, we are going to have to interrupt you. We have to go vote, and then we will return and continue your talk.

[Recess.]

Chairman MILLER. Sorry for the interruption.

Ms. KAUFFMAN. That's okay, I understand it was for a good cause.

I was discussing the problem of Fetal Alcohol Syndrome in Indian populations. The researchers in 1980 estimated that one in seven hundred and fifty live births were babies with FAS. Indian Health Service has estimated their FAS problem as high as ten in one thousand live births. However, in the book by Michael Dorris where he interviewed various Indian experts working in the field with Indian women, their estimates were as high as twenty to fifty percent of all Indian babies born were FAS.

"FAS" is diagnosed by basically a constellation of symptoms including facial deformations, low birth weight and mental retardation, in varying degrees. Many of these children are unable to take care of themselves when they grow up and require institutional care or some constant care. They also show up in special education classrooms. Without adequate training on how to make a diagnosis and without support for the children after they are born, they are basically children who are being born into a system that is not prepared to deal with them. The problem seems to be increasing.

Before moving here to Washington, D.C., I was the Director of the Seattle Indian Health Board in Seattle, Washington. That's a non-profit organization serving the health care needs of Indian people in that area. Included in our service program was the inpatient alcoholism-drug treatment facility called the Thunderbird Treatment Center.

A part of what we provided there included inpatient drug treatment for women. This was a program that we developed in response to growing need, but we realized that simply expanding the treatment program from the male treatment program to create additional beds for women was not enough. Women had unique need in the treatment setting.

One example that we had was an Indian woman who was on AFDC, made the decision to get into treatment, and she left her children in the household with her boyfriend who was taking care of them and she applied for state subsidized treatment and was accepted and enrolled into treatment. She was in treatment for about two weeks when she was notified that because she was accepted under the state paid treatment resource for low-income women, the state discontinued her AFDC eligibility until she completed the treatment. So, there was no longer financial support for her children while she was in the treatment program.

As a result of that news, she quit treatment and decided that it was better for her to be at home and to continue to try to take care of her children, and to use the state support to pay for the basic needs of maintaining her family.

We have other examples of women that wanted to get in to treatment but were afraid that if they take their children and give them to temporary foster care that they may not get their children back. Indian people have a very recent memory of the time before the Indian Child Welfare Act when up to thirty to forty percent of all the Indian children were being taken away and being placed in non-Indian foster homes, and eventually adopted and lost.

Although the Indian Child Welfare Act has provided additional protections against that happening it is still a dangerous situation for Indian women and they are leery of making that placement in temporary foster homes. There is also not always the extended family that is sober to take care of the children. So, it is a complicated process to get them into treatment.

The other problem we experienced in dealing with Indian women is that there's a large percentage of women in treatment who are also adult survivors of child sexual abuse. The treatment program we had developed was not designed to respond to those issues, and the difficult task of trying to build a bridge between alcoholism treatment and the mental health system began and it was a very difficult process.

I have not seen two professional disciplines that have so much in common, but yet have such a hard time speaking with each other and finding common ground to help clients as the substance abuse and mental health professions. I think if we can get those two professions dealing with each other in a little more formal way, and to try to streamline services available to people, so that they don't have to pick and choose between those two professions, it would help.

Finally, in my position as the President of the National Association for Native American Children of Alcoholics, I want to point out that the damage to children from alcoholism and substance abuse occurs not only in utero, but throughout their lifetime in a home that is disrupted by the chaos and violence that go along with addiction. For the Indian population we have estimates between fifty and eighty percent of the adults experiencing alcoholism or alcohol abuse.

That means the same percentage of Indian children are growing up in homes where they are most likely to suffer physical, sexual, emotional abuse and neglect. They are most likely to experience school dropout, or social isolation, chronic depression, low self-esteem, suicide, promiscuity, and eventually developing their own chemical addiction as they grow older.

These children need to be treated also. They need not just to be brought into the treatment setting with their parents, but they need their own unique treatment so that they can begin to overcome the traumas they have experienced, and the childhood that they were denied.

In summary, I would just like to say that the recommendations that we have here are specific and I hope that you can carry them to whichever committees are appropriate. I would like to see a multi-disciplinary approach that will bring in the mental health and child protection and alcohol treatment providers to deal with families as a whole, rather than dissecting them based on categorical funding criteria.

I'd like to see tribes establish treatment programs where women can bring their children with them, and children can get their own treatment. I think that we need to provide more training for medical providers on how to confront patients about alcoholism and other addictions, in a way that's going to support a treatment alternative.

We also need to provide training to community members and family members about how to confront loved ones with addictions. I discussed with some of my fellow panel members here the issue of involuntary civil commitment and I think that is something that needs to be looked at as an option. The only argument I have heard opposing this option so far is that there are not enough treatment beds for those that really want to get into treatment. It is an issue that needs to be looked at.

Certainly the biggest crime we have here is the fact that there are not enough treatment resources to respond to the need and if we could put nine billion dollars into treatment, I think the demand for drugs would drop substantially.

I think that the Indian Health Service needs to receive some fairly specific direction about developing services for Indian women around treatment. The model that it is using dates back to the 1970 NIAAA approach, and it is a very good foundation, but services need to be dedicated and set aside for Indian women.

I'd like to see some direction toward the Indian Health Service to end the wars between mental health and addiction treatment fields. I'd like to see the Indian Health Service develop specific funding around training providers to diagnose Fetal Alcohol Syndrome and to provide support for FAS babies and FASD adults in Indian communities.

And finally, I would like to see some attention to the needs of Indian children who are growing up in alcoholic homes. To provide them safe places, to provide them sober role models, so that the cycle of addiction can end. I would also like to mention that there are very specific cultural needs that Indian people have in terms of their own treatment and their own recovery.

I don't think that that is unique to Indian people. I think that the cultural oppression that different groups of us have experienced throughout history has a legacy that carries on for many generations, and that turns into a sort of chronic depression. The depression and the suicide and the chemical abuse experienced in

Indian communities has a strong relationship to the oppression that Indian people have experienced in the past.

Racism has had a big impact on how we have viewed ourselves and how much we can respond to the times when we do encounter racism in the broader community. If there is not that strong foundation, if we believe even any of the negative things that we hear, that undermines our wellness.

In closing, I'd like to say that Indian women, in traditional Indian teachings, have been given the role as the life givers, and the peace makers, and the spiritual centers of the family. We need to bring this teaching back. I appreciate this opportunity to be here. I think that this is a step toward replacing that role again. Thank you.

[Prepared statement of Jo Ann Kauffman follows:]

Prepared Statement of Jo Ann Kauffman, M.P.H., President, National Association for Native American Children of Alcoholics, Washington, DC

Mr. Chairman:

My name is Jo Ann Kauffman. I am the founding President of the National Association for Native American Children of Alcoholics, a non-profit advocacy and training organization formed in 1988. I am an enrolled member of the Nez Perce Tribe of Idaho. I hold a Masters Degree in Public Health Administration from the University of California at Berkeley. For the past seven years I was the Executive Director of the Seattle Indian Health Board, in Seattle, Washington. In this capacity I managed health services delivery for the 20,000 Indians and Alaskan Natives in the greater Seattle area, including the administration of a 95-bed inpatient alcoholism and drug treatment facility called the Thunderbird Treatment Center. In August of last year, I left my job with the Seattle Indian Health Board to relocate to the Washington, D.C. area where I now reside and work as a health policy consultant. I continue to volunteer my time with the National Association for Native American Children of Alcoholics.

The National Association for Native American Children of Alcoholics is most concerned about "breaking the cycle" of addictions in the Indian community. Multigenerational alcoholism and substance abuse among Indian families sets the stage for children to be born into an environment where, left untreated or unhelped, they will live to repeat the cycle. Today, many Indian families are experiencing substance abuse in their families at the fourth or fifth generation. The effects of the dysfunction related to addiction can be carried from one generation to the next. The overwhelming majority of Indian adults treated for substance abuse addiction are children of alcoholic parents.

Given the multigenerational effects of addiction, "punishing the addict" is hardly the solution to this complex problem. However, the safety of both mother and child must be protected and efforts to prevent and treat addictions and problems related to addiction in the family system must become a priority in this society. The following are the specific recommendations to this Committee related to "Law and Policy Affecting Addicted Women and Their Children" presented on behalf of NANACOA:

1. Federal, State and Local (including Tribal) authorities dealing with Child Protection, Substance Abuse Treatment and Mental Health Counseling must be provided the incentive to coordinate services to deal with the whole family, rather than dealing with each member of an addicted family based on categorical funding criteria of the respective government agency. Often the services available for the addicted mother are not able to resolved questions about child care, temporary child custody or family treatment while the mother is in treatment. This becomes a disincentive for the mother to seek treatment for her addiction.

2. Special funding should be provided for Tribes and Indian Communities to establish treatment programs for Indian women who want to keep their young children with them in the treatment setting. These family treatment models must include individualized support and treatment for the children as well.

3. Training should be provided to medical providers on how to confront a patient with alcoholism or other addictions in a way which will be supportive of addictions treatment alternatives.

4. Involuntary, civil commitment into treatment for pregnant or parenting women, whose addiction endangers the lives of their fetus and/or children should be examined and implemented by tribal communities as a final alternative to intervention, failing other means to intervene.

5. The Indian Health Service should be directed and funded to develop treatment modalities which deal specifically with Indian Women. The history of alcoholism treatment in Indian communities has shown that the current approach is targeted at the adult male population. Women's issues need to be better understood and supported. Child sexual abuse, relationship addiction, overeating, battered women's syndrome and cultural oppression of traditional roles for Indian women need to be addressed. Likewise, the unique strengths Indian women possess such as their value of the family, protection of the children can be utilized in the treatment setting to support their own recovery. Model treatment programs serving exclusively Indian women and their children should be funded by IHS to be accessible to Indian people in all geographic regions.

6. Barriers between the "Mental Health" and "Addictions Treatment" disciplines must be broken down and new treatment modalities which offer a long term recovery path, beginning with addictions treatment and continuing on to address the other mental health related issues of Indian women must be developed. The "turf wars" are killing Indian people.

7. The Indian Health Service must develop a more comprehensive approach to dealing with Fetal Alcohol Syndrome (FAS), to assure appropriate diagnosis and long term care. Special Programs including custodial support is needed for Indian people diagnosed FAS. This includes special learning programs for FAS children, support for their parents and living programs for FAS adults.

8. The Indian Health Service, the Bureau of Indian Affairs and Indian communities must provide support for Indian children of alcoholics or other addicted parents, so that Indian children can understand the addiction, learn to cope with the addiction in their family, learn survival skills to stay alive in the chaos of addiction and to find support and emotional nurturing from other adults while their parents are still actively addicted. This support will substantially improve the chances for these children to avoid repeating an addicted lifestyle when they grow up.

BACKGROUND ON ADDICTIONS IN THE INDIAN COMMUNITY:

The Indian Health Service data states that four (4) out of the top ten (10) leading causes of death for Indian people are directly related to alcoholism or alcohol abuse. These causes include accidents, cirrhosis, suicides and homicides. The mortality rate for Indian people dying from alcohol and its related effects is 5 times the rate for the general public. The Indian people dying from alcoholism and substance abuse are young, much younger than the general population. Lifestyle factors consistent with addiction, can also be involved indirectly in other causes of death and morbidity for Indian people. While the Indian Health Service boasts success at lowering the infant mortality rate for Indian babies, the data shows that the real improvement is during the neonatal period, from birth to 28 days. During the post-neonatal period, from 28 days to 12 months, the infant death rate for Indian children begins to rise above the national rate. The post-neonatal period is the time when the infant is in the home environment and most vulnerable to parental alcoholism, or other addiction among adult caretakers.

There are a variety of theories as to the disproportionate rate of alcoholism among Indian people. Some believe it is a genetic predisposition which makes Indian people vulnerable to the disease, alcoholism. Others believe it is a learned behavior, which began back in the treaty signing days when "fire-water" was a Euro-American gift and drunkenness a ritual of the event. Still others support the theory that Indian alcoholism is a symptom of the pervasive poverty, oppression, cultural loss and excessive grief experienced by Indian people through-out the generations. Overlay all these propositions and assume each of these theories has some validity, Indian people are at tremendous risk for alcoholism and other addictions.

In the early 1970's, the National Institute on Alcoholism and Alcohol Abuse (NIAAA) funded the development of Indian treatment programs through-out the United States. These programs were based on the 12 Step model of Alcoholics Anonymous and attracted mainly older adult, male, chronic alcoholics. In 1976, the Indian Health Care Improvement Act provided authority and direction to the Indian Health Service to assume responsibility for these NIAAA treatment programs and they were transferred to IHS, where they were refined and standardized. While the problem of alcoholism and other substance abuse began to change in Indian communities to become a problem among a growing number of Indian women and youth, the treatment effort changed slowly. The passage of the Anti-Drug Act of 1986 and related amendments in 1988, brought about rapid, broad-based, community level involvement in the prevention of substance abuse in Indian communities and a better understanding of the pervasiveness of the problem.

Today, Indian communities have a much better grasp on the complicated web of factors which undermine their wellness, but often lack the financial support or authority to address them. Communities such as Cheyenne River Sioux, Wind River and Flathead have proceeded to initiate community efforts to eliminate alcoholism and substance abuse. Understanding unique women issues in the treatment process has not been a major focus in Indian community treatment programs as it needs to be. Many Indian communities have come face to face with the issue of womens addictions in their effort to prevent fetal alcohol syndrome.

FETAL ALCOHOL SYNDROME (FAS) AND FETAL ALCOHOL EFFECT (FAE):

Recently data has become more available regarding Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) among Indians. Fetal Alcohol Syndrome is an entirely preventable birth defect found in children, caused by maternal intake of alcohol during pregnancy. The FAS child is generally diagnosed by a constellation of features including low-birth weight, characteristic facial deformities and mental retardation. Children diagnosed with FAE experience some, but not all of the FAS characteristics. Just as the incidence of alcoholism and alcohol related death is higher in Indian populations, the estimates of birth defects to Indian children due to alcoholism is also higher than for the general public. In 1980, Dr. Anne Streissguth a leading FAS researcher estimated that the rate of FAS babies born in the United States was 1/750 live births. The Indian Health Service estimates that the rate of FAS babies born to Indian women ranges from a low of 1.3/1000 in the Southwest to as high as 10.3/1000 among Plains tribes. These numbers are likely conservative, since little has been done to launch an effective educational training program for Indian providers to properly diagnose FAS in Indian communities.

A recent best selling book by American Indian author, Michael Dorris, titled "The Broken Cord", describes his personal struggle to raise his adopted son who is severely damaged by Fetal Alcohol Syndrome. His essay points to the many ethical questions related to FAS prevention. He describes his communication with Indian health care workers who estimate the real prevalence of FAS babies born in their communities to be between 20% and 50% of all babies. One community, he describes, seeks to pass tribal ordinances to jail Indian women who are pregnant and refuse to quit drinking. He also describes the problem of multigenerational FAS. That is, Indian women who were born to drinking mothers, and likely suffer from FAS or FAE themselves, and therefore cannot comprehend the prevention message. These women continue to give birth to their own string of FAS babies.

Missing from the arguments about whether to jail or not to jail pregnant Indian women, is the fact that the real crime is the conspicuous absence of treatment resources in Indian communities. Tribal and other Indian communities need to develop a means to intervene with a family where addiction is threatening the life of the children, born and unborn, and make the appropriate treatment intervention.

Involuntary substance abuse treatment has never been popular among treatment advocates because of the premise that the individual in treatment must accept the addiction as a problem as her first step to recovery. Incarcerating and punishing pregnant addicts is a simplistic approach to save the life of the unborn child, but offers little hope to break the cycle of addiction between mother and child. The child is still at risk for death, disability and addiction by growing up in the dysfunctional family system of an addicted parent. Involuntary civil commitment for substance abuse treatment should not be discounted entirely. It offers tribal and local jurisdictions authority to intervene if all other alternatives have been exhausted. Treatment of the addiction and treatment for all those family members affected by the addiction is the most important element to breaking the cycle of addiction.

CHILDREN OF ALCOHOLICS:

Children who grow up in the care of parents who are addicted experience higher rates of their own addictions and suffer other adjustment problems. It is estimated that there are approximately 28 million adult children of alcoholic parents in the United States. Until recently, little was known about the effects of growing up in an alcoholics environment. Specific dysfunctional characteristics can be identified among children of addicts.

In a family with alcoholism or some other addiction, the attention of the family caregiver is on the addict. The spouse and children learn to cover up and deny the significance of addiction. Young children in this setting learn that their needs are not important. The violence, disruption and unpredictability of the home environment leaves children suffering the delayed effects. Just like veterans from the Viet Nam War, children from alcoholic homes suffer from post-traumatic stress disorder later in life. The normal spontaneity and honesty of childhood is lost as the child confronts "denial" throughout the family environment. The verbal, physical and sexual abuse that often accompanies addiction in the home is also "denied" by the child. The COA Syndrome is a child's normal response to being placed in an abnormal environment. The three basic rules children learn to survive are:

1. Don't trust.
2. Don't talk.
3. Don't feel.

Children living in homes with addicted parents are more likely to experience physical, emotional and sexual abuse; social isolation; school drop-out; chronic depression; low self-esteem; promiscuity; suicide; and to develop their own chemical addiction. Left untreated, these children become adults who will marry another alcoholic or addict or become one themselves, and perpetuate the cycle to another generation of children born into addicted families.

TREATMENT RESOURCES AND POLICY:

While research supports that women will seek treatment inpart to keep their families together. Yet, there are numerous obstacles for women with children to get into treatment. Cost is a major obstacle. Women are less likely to have necessary insurance coverage. Childcare, however, is the most significant obstacle. Who will take care of the children while she is in treatment for 30 to 90 days? This is particularly true for Indian women.

There is a legacy of fear around the loss of Indian children to State or other authorities. For many years, up to one-third of all Indian children were being lost to non-Indian foster and adoption homes. Then with the passage of the Indian Child Welfare Act, tribes could protect the cultural integrity of the foster placement system so that Indian children were not lost from their tribes. But it is still difficult to coordinate foster placement of Indian children so that the mother can go into treatment. For many Indian women this is their primary obstacle to treatment. Low-income women who are one welfare, or Aid to Families with Dependent Children, will not want to give-up their AFDC support in exchange for State Paid inpatient treatment. Again, their concern is for their children.

If there are no other extended family members who are stable enough and willing to care for the children, the women in need of treatment will go without. The children need to feel that they are being cared for while the parent is in treatment. They need to have their own support system so that they can begin their own recovery from the effects of the addiction.

Adequate resources are needed to support low-income women who need subsidized treatment and support for their children while they are in treatment. Centers specifically designed to meet the treatment needs of women are desperately needed. An Indian treatment program in Oregon which offers inpatient care for women and their children, must place the names of Indian women from the States of Washington, Oregon, Idaho, Montana and Alaska on a waiting list because it does not have the capacity to respond to the demand for this kind of care.

SUMMARY:

Indian tradition teaches that women have a special role in the world. They are the "lifegivers", the peacemakers; the spiritual center of the family. The recovery of Indian women from alcoholism and addictions opens the door to family and community recovery.

The system that serves Indian communities must adjust its rules and policies to help this along. Indian child welfare for women in need of treatment must be guaranteed. Support for children of alcoholics and children of parents with other addictions must be provided for the family to begin its recovery. Treatment models which deal specifically with womens issues must be developed in Indian communities. Treatment centers which will provide a means for women to bring their children into the treatment setting will increase the number of Indian women seeking treatment.

The Indian Health Service must face the fact that more and more children will be born with disabilities due to alcoholism and drug abuse. A special initiative to deal with Fetal Alcohol Syndrome is needed for those children already born FAS and to prevent FAS in more Indian babies. Adequate planning to respond to this problem must take place immediately between the IHS, the BIA Child Welfare System and Indian community leadership.

Thank you for this opportunity to provide testimony.

STATEMENT OF ALBERT W. PRUITT, M.D., F.A.A.P., CHAIRMAN, DEPARTMENT OF PEDIATRICS MEDICAL COLLEGE OF GEORGIA; CHAIRMAN, COMMITTEE ON SUBSTANCE ABUSE, AMERICAN ACADEMY OF PEDIATRICS, AUGUSTA, GA

Dr. PRUITT. Thank you, Mr. Chairman. My name is Al Pruitt, I am Chairman of the Department of Pediatrics of the Medical College of Georgia. I also serve as the Chairman of the Committee on Substance Abuse of the American Academy of Pediatrics, and I am here today on behalf of my thirty-nine thousand colleagues in the Academy who are dedicated to the promotion of maternal and child health.

At the outset, I want to express to you and to the members of this panel the Academy's deep appreciation of your continued emphasis on these serious issues affecting addicted women and their children. As a nation we have not yet begun to come to terms with our tragic proliferation of drug exposed infants and children. But this series of public hearings under the auspices of the Select Committee offers real promise of progress.

For pediatricians, that promise is really all important. There are indications today that perhaps one of every ten infants is exposed to illicit drugs during pregnancy. More and more infants are being admitted to special care nurseries for complications caused by their intrauterine exposure to drugs of abuse.

It's heart rending to see many of these babies with birth defects, as a result of Fetal Alcohol Syndrome, for example, or to watch others struggle through withdrawal from drugs.

I come before you today as an advocate for these infants and children and for their mothers, whose persistent drug abuse problems our society simply must learn to address more sensitively and more successfully. The Academy believes the most appropriate way to prevent intrauterine drug exposure is to educate women of childbearing age about the hazards of drugs to the fetus, and to encourage drug avoidance.

If this fails, effective drug treatment programs must be made readily available to pregnant women, and to women who are anticipating, or who are at risk of pregnancy. Punitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits for infant health.

Similarly, mandatory drug screens of pregnant women, or screens without their specific informed consent, are not a adequate means of obtaining needed information. They are also potentially apt to be applied in a discriminatory fashion against poor and minority women.

Pediatricians are extremely concerned that some punitive or clandestine steps, however well intentioned the State or localities, may only succeed in discouraging these vulnerable women from receiving the very prenatal care and social support system that is so crucial to their treatment.

Once a baby is born, the issues of consent and confidentiality for pediatricians become substantially more complicated. The best interests of the infant are paramount. Since there are well documented potential adverse affects on children exposed to drugs in utero, pediatricians must reasonably seek to identify drug exposed infants.

That is most prudently and effectively done by obtaining a thorough maternal history from all women in a non-threatening and organized manner. The Academy strongly opposes universal neonatal screening for illicit drugs. The long term consequences of such a policy, that is to say the harms versus the benefits of labeling an infant as drug exposed, are not known.

In addition, some drug exposed infants will be missed if physicians rely solely on toxicology screens for diagnosis. For example, screens will surely be negative when drugs were used only early in pregnancy, and can be negative even when women have taken drugs in the forty-eight hours before delivery.

When medically indicated, and necessary, however, pediatricians do, and ought to, undertake neonatal drug screens even without receiving the informed and specific consent of the mother but as a part of the medical evaluation of a sick newborn infant. Upon receiving a positive result, it's our custom, based on long experience, to meet with the mother or parents and discuss with understanding and calm the implications of this information on their family.

Infants and children of substance abusing parents are at increased risk for physical, sexual, and emotional abuse. As pediatricians, we want newborns to begin their lives, not only healthy themselves, but in a healthful family environment. To that end, we use our best judgement in an effort to deal with problems of parental substance abuse personally and privately, but we also recognize that the assistance of hospital social services is often essential, and that local child protective services may well be needed.

In each of these options, our overriding intentions is affirmatively to support the child and the family. As a rule, confidentially is central to a successful outcome, but in all honesty, issues of this nature are case by case, and they frequently require considerable flexibility. In sum, Mr. Chairman, pediatricians are committed to do everything possible to improve the plight of addicted women and their children, but all too often, as certain states and localities move rashly, we are learning first and foremost what not to do.

Prosecution, incarcerations, arbitrary drug screens, and other punitive sanctions offer no long term solution, they only serve to satisfy our short term need as a concerned people to do something.

It's our hope that this committee in its wisdom can sort out the promising opportunities for public policy in behalf of addicted women and drug exposed infants, and then exert its leadership behind necessary legislation. The Academy will be there in support. Thank you.

[Prepared statement of Albert W. Pruitt M.D., follows:]

PREPARED STATEMENT OF ALBERT W. PRUITT, M.D., F.A.A.P., CHAIRMAN, DEPARTMENT OF PEDIATRICS, MEDICAL COLLEGE OF GEORGIA; CHAIRMAN, COMMITTEE ON SUBSTANCE ABUSE, AMERICAN ACADEMY OF PEDIATRICS, AUGUSTA, GA

Good morning, Mr. Chairman. My name is Dr. Al Pruitt, and I am chairman of the department of pediatrics at the Medical College of Georgia in Augusta. I also serve as chairman of the Committee on Substance Abuse of the American Academy of Pediatrics, and I am here today on behalf of my 39,000 colleagues in the Academy, who are dedicated to the promotion of maternal and child health.

At the outset, Mr. Chairman, I want to express to you and to the members of this panel the Academy's deep appreciation of your continued emphasis on these serious issues affecting addicted women and their children. As a nation, we have not yet begun to come to terms with our tragic proliferation of drug-exposed infants and children, but this series of public hearings under the auspices of the Select Committee offers real promise of progress.

For pediatricians that promise is all-important. There are indications today that perhaps one of every 10 infants is exposed to illicit drugs during pregnancy. More and more infants are being admitted to special-care nurseries for complications caused by their intrauterine exposure to drugs of abuse. It is heart-rending to see many of these babies with birth defects (as a result of fetal alcohol syndrome, for example) or to watch others of them struggle through withdrawal from drugs. I come before you today as an advocate for these infants and children, and for their mothers, whose persistent substance abuse problems our society simply must learn to address more sensitively and more successfully.

The Academy believes that the most appropriate way to prevent intrauterine drug exposure is to educate women of childbearing age on the hazards of drugs to the fetus, and to encourage drug avoidance. If this fails, effective drug treatment programs must be made readily available to pregnant women, and to women who are anticipating or who are at risk for pregnancy.

Punitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits for infant health. Similarly, mandatory drug screens of pregnant women, or screens without their specific informed consent, are not an adequate means of obtaining needed information--they are also potentially apt to be applied in discriminatory fashion against poor and minority women. Pediatricians are extremely concerned that such punitive or clandestine steps, however well-intentioned the states or localities, may only succeed in discouraging vulnerable women from receiving the very prenatal care and social support system so crucial to their treatment.

Once a baby is born, the issues of consent and confidentiality, for pediatricians, become substantially more complicated. The best interests of the infant are paramount. Since there are well-documented, potential adverse effects on children exposed to drugs in utero, pediatricians must reasonably seek to identify drug-exposed infants. That is most prudently--and effectively--done by obtaining a thorough maternal history, from all women, in a non-threatening, organized manner.

The Academy strongly opposes universal neonatal screening for illicit drugs. The long-term consequences of such a policy, that is to say, the harms versus the benefits of "labeling" an infant as drug-exposed, are not known. And strictly on medical grounds, the fact is that some drug-exposed infants will be missed if physicians rely solely on toxicology screens for diagnosis. (Screens will surely be negative when drugs were used early in pregnancy, for instance, and can be negative even when women have taken drugs in the 48 hours before delivery.)

When medically indicated and necessary, however, pediatricians do and ought to undertake neonatal drug screens even without receiving the specific informed consent of the mother (but only as part of a medical evaluation of a sick, newborn infant). Upon receiving a positive result, it is our custom based on long experience to meet with the mother or parents and to discuss with understanding and calm the implications of this information on their family. Infants and children of substance-abusing parents are at increased risk for physical, sexual and emotional abuse. As pediatricians, we want newborns to begin their lives not only healthy themselves but in healthful family environments.

To that end, we use our very best judgment in an effort to deal with problems of parental substance abuse personally and privately. But we also recognize that the assistance of hospital social services is often essential, and that local child protective services may be needed as well. In each of these options, our overriding intention is affirmatively to support the child and family. As a rule, confidentiality is central to a successful outcome. But in all honesty, issues of this nature are case by case, and they frequently require considerable flexibility.

In sum, Mr. Chairman, pediatricians are committed to do everything possible to improve the plight of addicted women and their children. But all too often as certain states and localities move rashly, we are learning first and foremost what NOT to do. Prosecutions, incarcerations, arbitrary drug screens and other punitive sanctions offer no long-term solution--they only serve to satisfy our short-term need as a concerned people to DO SOMETHING.

It is our hope that this Committee in its wisdom can sort out the promising opportunities for public policy in behalf of addicted women and drug-exposed infants, and then exert its leadership behind necessary legislation. The Academy will be there in support.

Chairman Miller. Thank you. Mr. Ryan, let me ask you what we know about the law. It's been in existence since January; is that correct?

Mr. Ryan. That's correct.

Chairman Miller. Do we have any anecdotal evidence or any indications of what's happening as a result?

Mr. Ryan. Well, Mr. Chairman, it's a little early to reach many conclusions about the law because it's only been in effect since January, which means it's been in effect less than five months. In my office, we have found it is easier now, in court, to prove neglect, because of the change in the law. But, to demonstrate any remarkable change in the numbers or figures, I can't do that now, because the law has only been in effect a short time.

Chairman Miller. It's easier to prove neglect because what's happening? I mean is testing taking place because of the law, and then are those cases being referred? I'm asking how's it working, I'm asking for results as to whether or not——

Mr. Ryan. I think it's working well from the experience we have had with it. It is easier for prosecutors in court, in juvenile court, in DuPage County, to prove neglect, under this new law. That in turn makes it easier for the court to intervene early to provide, or see to it, that treatment and services are provided to these infants.

Chairman Miller. I don't know DuPage County, but what about in terms of, I guess balance, in where the cases are coming from. Are they coming from a cross section of hospitals and populations, or is that being monitored to determine how it's being imposed?

Mr. Ryan. In DuPage County, Chairman?

Chairman Miller. I guess.

Mr. Ryan. Well, eighty percent of the cases in Illinois that are referred to the Department of Children and Family Services, come out of Cook County. We have actually had a relatively small number in DuPage County, certainly by comparison. But I do agree with testimony that was elicited here today, that probably we're only seeing the tip of the iceberg, and that these cases are under reported.

Chairman Miller. Let me ask you, Ms. Moss raised the issue about sort of unequal enforcement, or what have you, of the law here. I know in my own area, hospitals and upper income cities and neighborhoods are very reluctant to even engage in the discussion of drug abuse among their patients, or to think about testing for that. What's happening in Illinois?

Mr. Ryan. Well, I think that some of the testimony that was elicited here today is probably correct, in that there are more reported cases involving the poor and minorities than in other population groups. That is unfortunate, and we should work to eliminate that.

Chairman Miller. This law speaks to illegal drugs. Ms. Kauffman talked about Fetal Alcohol Syndrome, which of course is a huge, huge problem again just in terms of numbers. I mean it's a very large number of affected children. Is there a reason that alcohol was not included in the Bill?

Mr. Ryan. Initially, when we drafted the bill, we wanted to see something passed that would improve our ability to direct services quickly to drug exposed infants. Alcohol is a legal drug, as you know, whereas cocaine and other controlled substances under Illinois law are not.

So, it was a practical consideration, but I share your concern for infants that suffer from Fetal Alcohol Syndrome and now that this is the law in Illinois, I think we should give serious consideration to adding to that piece of legislation infants that are diagnosed or are suffering from Fetal Alcohol Syndrome.

Chairman MILLER. Obviously, if you abuse alcohol and you're drunk and you beat your children, that can be an indicator of neglect and you can be charged in that fashion. By the same token, if you abuse your body and you pass on Fetal Alcohol Syndrome, and the affects to children, it seems to me, it's sort of one and the same preposition as illegal drug use prenatally. Not to agree, or disagree, for a second about whether this the direction you want to pursue in terms of dealing with these prenatal acts. It seems to me that it is essentially kind of the same thing.

At this point, a Fetal Alcohol Syndrome child can be every bit as impaired and even more impaired than many of the cocaine-exposed children, as we're learning now more and more about some of the cocaine babies. There's going to be a whole gradation of impact on these children from essentially de minimis to very severely impaired in one fashion or another. The same is true in terms of alcohol, and I just think that is going to have to be an option if you're going to pursue this. It's not a status of the substance, I think, in and of itself that can be the indicator of neglect. I think it's the abuse and the result that you want to look at. That remains to be seen. Ms. Moss, you look like you're waiting to say something here.

Ms. MOSS. I did want to respond to Mr. Ryan's discussion of the effect of the Illinois law. Our local ACLU affiliate has been monitoring the effect of that law and has found in the few short months that it has existed, that it has resulted in the removal of hundreds of babies from their mothers, solely on the basis of a positive toxicology. No searching review of the parenting abilities of the mother or the father is occurring. What has happened instead is that the babies are being warehoused right now. One center in particular is called, I believe, Columbus Facility. Babies are not getting any of the services they might need, nor are they being assigned a case worker. We are very concerned that adequate services exist to take care of these infants. If they do not then you are really creating a situation that is not in the best interest of the children. That is important.

The second point that I wanted to make is that I think there is a difference between the parent who is an alcoholic and beats their child, and the woman who ingests drugs while she is pregnant. In the latter case, the woman is hurting herself, she is not hurting an already-born child. Punishment therefore, raises constitutional issues of privacy, and bodily integrity that are not otherwise implicated.

Chairman MILLER. I think there are some differences, too, I'm just saying in terms of the internal consistency. If we're going to look at a child, and we're going to test the child for illegal drugs, and we're therefore going to say that proves neglect. When you look at a child who's badly deformed because of Fetal Alcohol Syndrome, then isn't it the same burden of proof?

We can argue over whether or not you want to take the action of ingesting alcohol or illegal drugs, but once you've headed down that road, it seems to me, that when all the evidence suggests that the abuse of alcohol, in many instances, will be just as harmful to the child as the abuse of cocaine, or something else, there's got to be a certain parallel that's set up here.

Sort of like saying, we'll arrest you for speeding, only if you drive Cadillacs. No. Both cars can do the damage.

Ms. Moss. That also presents the problem of the "Slippery Slope." Once you open the door so that the state can intervene for illegal behavior, where does it stop? Where does the road stop? Many kinds of behaviors that a mother may engage in during pregnancy may harm the fetus.

Chairman Miller. I understand that, but I'm just wondering the logic of why you stop at various places. It may be, we know that nicotine is an addiction, and it may be that you want to expand it there. I'm just working down this logic of this process. The question of whether or not you want to do this is obviously already discussed. Let me ask you something. Dr. Pruitt, when we do this, you mentioned confidentiality, and maybe Mr. Ryan can help here, but what's brought into this process?

Are a woman's medical records opened up under this process? What is opened when you have this positive test of the infant? Because you don't necessarily have a positive test on the mother, is that correct, Mr. Ryan? This is just on the infant?

Mr. Ryan. Right. It's not a mandatory test. If it turns up that there's a positive test, that has to be reported to the Department of Children and Family Services. But it is the infant, not the mother, we're talking about.

Chairman Miller. What's that call into question in terms of evidence, after that?

Mr. Ryan. The Department of Children and Family Services then has the option of either looking into it, informally, and seeing to it that the child is being properly cared for, or can file a petition or ask the State's Attorney in the county where it occurred, to file a Neglect Petition in Juvenile Court. Then, of course, the respondent mother is brought in and there is an adjudicatory hearing to determine whether or not this is in fact this child is neglected under the statute. Then, if there is a finding of neglect, there is a dispositional hearing. At that dispositional hearing there is a determination made in terms of what's the proper response.

To simply say that all these children, or most of them, are being removed from their families, isn't true. It is, of course, one option. If a child is in danger of being put back in a family, involving a drug abusing mother, and is at risk, then the court has an obligation in the best interest of that child to remove the child from the home and put them in foster care.

But the Juvenile Court Act attempts to reconcile families, not divide them. That is only one response under more extreme circumstances. The other responses are simply, you could put the child back in the family, but now the Department of Children and Family Services can monitor the child's progress.

Columbus-Maryville Hospital, Ms. Moss mentioned, is Columbus-Maryville Reception Center in Chicago, is not simply a warehouse. I don't know if she has ever been there, I have. It's run by Father John Smyth, who's a marvelous, caring person. They have some staff members there who are excellent, and they're doing some very good work.

I had an opportunity, when this Bill was signed by the Governor, to tour Columbus-Maryville Reception Center. If you ever want to see something that's heart rending, walk through there, and see these children hooked up to life-support systems because they stop breathing without much warning. They are doing some important work there. Just to characterize it as a warehouse would be, I think, to do an injustice, to them and the work they are doing.

Chairman MILLER. Dr. Pruitt, it seems to me in some instances you are talking about a doctor who may be seeing a patient for the first time, making a delivery. In this case certainly in urban hospitals, where this seems to be the case, in making a delivery, he or she may decide there's indicators of drugs; and may decide to test this child as part of treatment here. He may have a child that's in a lot of trouble.

In another case, you may have a doctor that may be seeing a woman over a number of years, or a number of months, and now that's brought into neglect. Is this medical record, is the doctor's knowledge, is that part of this process? In determining neglect? Mr. Ryan, is that correct?

Mr. RYAN. Under this law, as a matter of law, once it has been proven in court that there was a positive test, that child is per se neglected.

Chairman MILLER. That's neglect?

Mr. RYAN. Now, there are a whole host of responses that the court can turn to.

Chairman MILLER. I understand that.

Mr. RYAN. But that is neglect. That gives the court——

Chairman MILLER. So there's no need to go back under this statute. You don't have to go into a person's medical records? That test, in and of itself?

Mr. RYAN. That test in and of itself would be sufficient, to prove neglect. Now, again as I pointed out, the court can then make a number of responses.

Chairman MILLER. Dr. Pruitt?

Dr. PRUITT. I certainly think that as a part of normal prenatal care, that obtaining the history and counseling the pregnant woman about the dangers of exposure of the fetus to drugs, is a part of prenatal care. And you would talk about it in terms of alcohol exposure or other drugs. So you gather the information in that kind of medical environment. You are doing it with counseling, because I think we really do find that large numbers of women don't understand the danger of this. They're just not aware of the danger.

There are many women who don't understand still the danger of alcohol exposure to the fetus.

Chairman MILLER. That's not a defense here, apparently. Mr. Durbin.

Mr. DURBIN. Thank you, Mr. Chairman. I'm sorry I came in late, but I have reviewed the testimony and I have a few questions. Mr. Ryan welcome. Being from Illinois, and having worked in the Illinois General Assembly, I probably worked on some of the Committees you spoke of before, in creating this legislation. It strikes me that this panel is addressing, at least part of the panel is addressing, an area that is ethically challenging in terms of whether we are about to try to construct piecemeal some new definition of child abuse and neglect in the United States. Which extends beyond the current limitations, and extends to the womb. At this point, from what I gather, Mr. Ryan, your legislation, first let me ask, it's under the Juvenile Court Act and not under the Criminal Code?

Mr. RYAN. That's correct. This doesn't permit prosecution in adult court.

Mr. DURBIN. It does not?

Mr. RYAN. Does not.

Mr. DURBIN. Does not.

Mr. RYAN. It's neglect, not abuse and it's handled through Juvenile Court.

Mr. DURBIN. Which is interesting, because we are dealing with two acts which society generally abhors, drug abuse, on one hand, and drug abuse during pregnancy, which puts the child at risk. The decision to put this under the Juvenile Court Act means that the goal is not to punish the mother, from what you've said, but rather to protect the child and offer treatment to the mother. If I follow your testimony, is that a fair summation?

Mr. RYAN. That's correct.

Mr. DURBIN. It leads me to the same question that was asked by Chairman Miller, if the real goal is to protect the infant, in utero, then why do you stop with drug abuse? To suggest that alcohol is legal begs a question. If the abuse of alcohol by a pregnant woman is going to do serious harm to the infant, that I think should fall under the purview of what you've suggested is the goal—protecting the child.

Similarly, what we hear from prenatal experts is that tobacco use by pregnant women can also be harmful to the fetus as well as obviously insufficient prenatal care. Why did you just draw the line then, when it came to drug abuse, to create your law?

Mr. RYAN. Well, first of all, there was a practical consideration of what it would take to improve the law and get it passed through the General Assembly. This particular piece of legislation made its way through the General Assembly and there were plenty of Democrat and Republican representatives and senators that could have amended the legislation. They didn't.

It enjoyed bi-partisan support. It flew through the General Assembly, and was signed into law. I'm not suggesting that this is the only way to approach the problem, or that there isn't a way to improve this law. Fetal Alcohol Syndrome is a terrible problem and it may very well be that this law should be amended, now that we have it on the books, to include children that have been diagnosed to be suffering from Fetal Alcohol Syndrome. Obviously, those cases involve mothers who have been abusing alcohol, to the detriment of their newborns.

Mr. DURBIN. Are you prepared to ask for an amendment to the law which would extend the concept of neglect to the mother who did not seek prenatal care during her pregnancy?

Mr. RYAN. I'm sorry, would you repeat that?

Mr. DURBIN. Are you prepared to amend the law to extend the definition of neglect to include the mother who does not seek prenatal care?

Mr. RYAN. No, I wouldn't be prepared to do that. This bill is designed to address what I consider to be a growing problem of illegal drug use by mothers, with a tragic consequence of their children being born drug addicted or drug exposed. I am certainly willing to look at amending this law to include those children who are suffering and have been diagnosed as suffering from Fetal Alcohol Syndrome.

To go beyond that, I'm not prepared to say I would do that today.

Mr. DURBIN. I don't want to, I guess the nature of this hearing is to put you on the spot, I don't want to put you on the spot. I'm really trying to plumb the depths of this theory, as to how far you would go, because the mother who wouldn't seek prenatal care and gives birth to a low birth weight child, is in many instances, contributing to the highest infant mortality rate in the western world, here in the United States.

In portions of Chicago, and even in downstate Illinois, it is a very serious problem, and I'm wondering why we, at least in our own home state of Illinois, have drawn this line so comfortably when it comes to drug abuse, but are very reluctant to take it the next logical step, if the protection of the child is our real goal.

Mr. RYAN. There's no question that the protection of the child is our real goal, and I think this law is working, and I think historically when we look back we will see that it was something that we need to do, and we'll be glad we did it.

It can be improved upon, I'm sure, and I'm certainly willing to look at other possibilities. I think Fetal Alcohol Syndrome is obviously a terrible problem and that may, and should be included possibly, in the context of this legislation.

Mr. DURBIN. Thank you. Dr. Pruitt, if I could ask you a question, perhaps you can help resolve another dilemma that I face in my own community. There is a divergence of opinion among social workers in my community who work with pregnant mothers.

Many conclude that if we required some type of drug screening during prenatal care, that it would discourage many mothers from seeking prenatal care. Perhaps those who have a drug habit, or those who suspect they may have crossed the line and are close to having a drug habit.

Now, there are other social workers who feel just the opposite. They tell me the only way to get many mothers to come clean and to concede they have a drug problem, is to let them know in plain and simple terms, that if they don't do something to enter a drug rehab program, during their pregnancy, and in the course of delivery it is established that their child is drug dependant, they will lose their kid. That, and that alone is the only force to motivate that mother to do something. Now, how do you resolve those two?

Because if the second social worker is right, then you can make a pretty compelling argument for drug screening.

Dr. Pruitt. I'm very concerned if you are forcing the mothers to undergo drug screening, and then an enforced incarceration, or treatment program that they object to, during the time of their pregnancy, then we're going to remove them from the prenatal care arena.

Mr. Durbin. No, excuse me. If in fact, I think what you said was that if they do not voluntarily participate and are incarcerated, you would remove them from the prenatal care arena?

Dr. Pruitt. Because they don't want to enter into a system that is going to lead to their incarceration, then they will not enter into the prenatal care system. I certainly do think that as a part of prenatal care, you ought to be enquiring and counseling with and talking with mother about drug use. I think that people who are very skilled in getting this kind of history are really quite successful. I know their data show from some studies, history is only fifty percent accurate, and that the drug screen is essential.

I think other people who have lots of experience in obtaining the history from mothers and have developed the relationships, find that they can get the information from the mother, and they can counsel with the mother. They make arrangements for getting into volunteer treatment programs, or depending on the level of use that the mother has, do an intervention that way.

Mr. Durbin. Can I give you a hypothetical?

Dr. Pruitt. Yes.

Mr. Durbin. What if an obstetrician is treating a mother who has already given birth to two drug dependant babies. At the time that this woman presents herself, she clearly is drug addicted herself. The doctor counsels her and says he wants to see her the following week and every week thereafter, in an effort to get her to break her drug habit.

Dr. Pruitt. I think that——

Mr. Durbin. If I can finish. She doesn't show up for several months. What obligations does society or that doctor have at that point?

Dr. Pruitt. Oh, no, I think that certainly one needs to call upon your child protective services for assistance. You have two children who been born who are addicted. The mother has not been keeping appointments and you have all sorts of signs of risk there. These children are at risk. The way you would intervene then is by child protective services.

Mr. Durbin. You would call child protective service and report that you have suspicion that she is a neglectful mother?

Dr. Pruitt. If she's not keeping her appointments, yes. If she is not keeping her appointments and I note this past history.

Mr. Durbin. Well, I just wonder what substantive difference there is, to that approach than to drug screening during the pregnancy. You are putting her into the legal system, one way or another, when she's uncooperative.

Dr. Pruitt. I think another point of course, to be made about drug screening is that you are really just selecting a period of time. I think the history is a much more ongoing thorough way of getting the information that you want. I think we would rely on drug screen to be positive, where at the time that you do the drug screen, obviously you are just looking at what's going on as far as drug use in the previous day or two.

Mr. Durbin. Thank you.

Mr. Holloway. Thank you very much, Mr. Chairman. I have a question for Ms. Moss, coming from a statement from Dr. Pruitt's testimony here stating that the basic information that you all achieve would be from questioning, or from the history, or from what the mother tells you.

Maybe I'm a good old country boy from the south, but something tells me that a lady that's addicted with drugs isn't going to admit it. I don't agree with questioning a person who's on drugs and simply taking the word of what she's telling me as the truth. Is there any point when you feel that there is a need for testing or do you absolutely think that we have to protect only a mother's right and forget about the right of the infant?

Ms. Moss. I think you raise a very important point, which is the importance of the doctor/patient relationship. Women need to believe that they can trust their health care providers, that they can be honest and reveal all the information that is necessary for that health care provider to provide the best quality of care both to her and her developing fetus.

I do think that testing is appropriate for purposes of medical intervention. I think that once you start extending that, and allowing other kinds of intervention, you begin to create a situation in which the woman is not going to trust her health care provider. We in fact have seen that women will not go to their health care provider if they believe that they will be criminally prosecuted or if they fear that they will lose their children.

As long as we have that kind of information, I think that's a real disincentive.

Chairman Miller. Let me just interrupt her for just a second. Dr. Pruitt, you've got to catch a plane, and this hearing has gone on much longer than we told you it would. Does anybody have a quick question for Dr. Pruitt, because I don't want to hold him here. We can submit questions to him in writing. Thank you very much.

Mr. Holloway. Two follow ups on that. Number one, what happens when the lady walks in just for delivery? Number two, do we want to wait for more babies while she's developing this relationship you're talking about with this doctor?

I have some severe questions on the time it takes for her to develop this relationship you're talking about and the care for this child while this relationship is developing. I'm not nearly as worried about the relationship as I am the care and the benefit of this child that's being born. We have two lives here, not one.

Ms. Moss. I'm also very concerned with the care of the child and that's what fuels the policies we have been recommending. We have existing systems that are designed to take care of the woman who walks into a hospital just to deliver. I mean we don't always know, for example, that a woman who comes into a hospital to deliver, did not have prenatal care.

For example, we had a case out in California where a woman just happened to be traveling and happened to in an area where she delivered a baby. The hospital presumed that she didn't have prenatal care, when in fact she had.

Mr. Holloway. I don't argue with you there, because we can find the exception to any rule here on the hill. There are too many people in America, and we can always find an exception. We can make exceptions to any argument that's ever been heard on this hill. I'm talking about the ninety-nine out of a hundred.

Ms. Moss. Existing systems can still take care of these women. Let's say that a woman walks in off the street, says that she has not had prenatal care, does not have an admitting physician, and appears to be intoxicated. This is a woman at risk. We need to look much more carefully at what's going on. We need to bring in social services and take a look at this family. I mean, absolutely, it's just extending it to automatically removing the child or putting her in jail that we object to.

Mr. Holloway. Well, I'm not too big on attorneys to start with, so I do have a problem with dragging things out for their benefit. We seem to do that in this country. I'm not very worried about anything other than what Mr. Ryan's trying to do here, giving someone the option to adopt or to take these children away from a home.

I don't care if we have an isolated case here and there of something happening. You undoubtedly do, and it's your battle cry. I worry about 99 of 100 babies who are born in one of these homes with no one trying to speed up the process of caring for these children.

Undoubtedly in this country, we care too much about protecting the right of one and giving up the right of 99. I have a problem with that and your argument on the case. I'd like to ask a follow up from Mr. Ryan. He knows where I'm coming from, and I'd like to know if he has anything to say.

Mr. Ryan. Well, I think that you are quite right, and the focus has to be not only on the woman's right and her relationship with her physician, and confidentiality, but we also have to be concerned about the right of that child that's born drug addicted or exposed to illegal drugs. The fact of the matter is, that child has rights, too.

To simply put that child back in the home where there may be drug abuse running rampant, is obviously not in the best interest of that youngster. I think it's important that we create the ability for the court, or the Department of Children and Family Service in Illinois, to step in quickly and examine the circumstances surrounding this child's well being. If the child can safely go back home, that's fine, and that's exactly where that child should be.

Then the Department of Children and Family Services or whatever welfare agency is involved can monitor that's child's progress, and make sure that the child is being treated properly. On the other hand, if to put that child back in the home, is to place that child in serious jeopardy, then the court has an absolute obligation, it seems to me, to take the child out of the home, at least temporarily, and put it into foster care.

It's important because it's clear, and I don't pretend to be a doctor, but Dr. Ira Chasnoff and others have made it clear, that the longer these children go without services and treatment and help, the more at risk they are. So, I think it's important to give society a book to give us a opportunity to get in there and take a look at what's going on in the life of this infant.

Mr. HOLLOWAY. I'll close saying that I commend you on your bill. I hope that you will look at it from an alcohol side and other sides to expand it. I think that you are headed in the right direction. In my opinion, you're doing it without abusing the rights of the mother by forcing her into care. But I do hope that you will continue to look into and develop the policies that you are implementing there in Illinois.

Mr. RYAN. Thank you, Congressman.

Mr. HOLLOWAY. We appreciate you coming forth today, and the rest of the witnesses. Thank you.

Chairman MILLER. Dennis.

Mr. HASTERT. Thank you, Mr. Chairman. I want to go back a little to the genesis of the cocaine baby bill as it was called. I think the bill encompasses all controlled substances, doesn't it Mr. Ryan?

Mr. RYAN. Yes, it does. It involves any controlled substance.

Mr. HASTERT. That was the crisis at the time, isn't that right? Sometimes we are in the business, especially as legislators and congressmen, of managing crisis. Did that tend to be the crisis at the time, in Illinois?

Mr. RYAN. Well, that is true, and then there is the practical consideration of what it would take to get something passed in the general assembly so that we could address the problem quickly. But, I think Congressman Durbin's point is well taken, that now I think we ought to look at including in the definition of neglect, a child that is born and has been diagnosed as suffering from Fetal Alcohol Syndrome. Obviously, that's a terrible problem, no less a problem, and that child is in no less danger than a child that has a controlled substance in his blood or urine.

Mr. HASTERT. But the problem in the immediate home and the immediate family may be more at a crisis level if somebody is a controlled substance user. I mean, there are degrees here,

Mr. RYAN. Well, the cocaine babies, the evidence suggests that cocaine babies are much more likely to die for example of Sudden Infant Death Syndrome. If you don't intervene quickly, you may have a dead child on your hands. That's just the plain simple fact of life, and so it does present some unique challenges to the medical community and to those of us in law enforcement.

Mr. HASTERT. One of the things that your bill does, as I understand it—I have been away from the Illinois General Assembly for a while, but I have tried to track it—is allow DCFS to intervene. One of our frustrations when I was in the general assembly, was that if we tried to move the child, those children who were most able to be adopted, first you had to get the severance, and then you had to have the courts intervene. What your bill really does is to say the courts, the juvenile justice system and the courts, can come in and DCFS can come in and make a determination on what's best for that child.

Mr. RYAN. That's correct.

Mr. HASTERT. That's the crucial thing. Sometimes our laws force the bureaucracy to stretch out and stretch out and stretch out determination. I commend you on what you're doing. One of the things that the court can do is to decide to put that child back with the family. I mean, it's not tied down, or a set predetermined decision; is it?

Mr. RYAN. No, it is not. With respect to the question of reporting, and mandating that doctor report this to the child protective agencies, in Illinois it happens to be DCFS, doctors in Illinois, and I'm sure if not in every state, in most states, are mandated reporters. They're required to report suspected cases of child abuse and neglect.

This is simply an expansion of that. It says that if you detect a presence of an illegal drug, in the blood or urine of this infant, you should report that to someone. It seems to me that is the only responsible way to proceed.

Mr. HASTERT. One thing further, I'd like to take exception to the caricature of warehousing babies at Maryville Reception Center. I know of that institution, and I know of the work of Father John Smyth, and it's exceptional in the state of Illinois. Mr. Chairman, I would like leave to enter into the record a period of time in two weeks that we can submit testimony from that reception center added to the record.

Mr. MILLER. I'm without objection.

Mr. HASTERT. Thank you. Mr. Ryan, I appreciate your being here. You know, we talk about problems and try to talk about solutions, what you have done in Illinois with your cocaine baby bill, is acted. You've created a solution to the problem, and we'll all watch that and track that very, very closely. It goes along with the history of other family issues that you have attacked and solved in Illinois. So I appreciate you being here today.

Mr. RYAN. Thank you, Congressman.

Mr. MILLER. I guess, Henry, I'm going to give you a second, because we're going to wrap up here, because I've got a meeting with the speaker, but I just want to jump in here. I guess what concerns me about this, and I am concerned is that, this committee has spent a number of years and has listened to and well documented the fact of thousands and thousands of women, among hundreds of thousands of people have sought out help and have been denied that help.

When we're talking about addiction, we know we have colleagues in this body that can't give up addictions. We've watched colleagues lose this job because they couldn't give up the addiction. We watch pro football players making millions lose it all, and my concern is that when we move down this model, we are essentially deciding that—Dennis just said this solution—this almost to me is an admission of failure. Finally what we're going to do is the end of the process, we're going to make this mother be charged with neglect, find her with neglect, prima facie evidence, and we don't know that to be the case.

Ms. Kauffman, I have visited reservations where a mother could not get help and may have been addicted since the time she was 10, 11, 12 years old. She couldn't get help if she sought it out all day long. And yet, we all act like addiction is willful.

One of the things that concerns us about crack, is that we were told here in the early hearing, that if you try it once, its the most addictive, overwhelming sensation you can feel, and you immediately want it again. As opposed perhaps, to other drugs that took longer, and people could experiment or change their minds.

I'm not passing judgment on the behavior, because obviously the goal here is not to use drugs the first time. It's to have a drug free pregnancy, but I see us moving in the opposite direction because of the failure of services. You can go to your suburban district and talk to young kids about alcohol, and they are shocked when you tell them this will have an impact on the fetus.

We are missing all of those opportunities and now at the end of the process, you have a baby, and boom! This is your problem and this is a concern. I don't know that you're wrong. I'm not suggesting that you're 100 percent wrong, or 20 percent wrong, or anything else, because we're all groping for these solutions.

But I am a little concerned that we cut back on family planning, you can't have an abortion because we made those determinations, you can't get health care services in many, many of these communities. We know that with people that don't have drug problems, and are trying to have healthy babies. Then at the end we engage in this.

To me that is like a failure of policy as opposed to, we made the first class effort and these are the exceptions, it almost seems to me we are going the other way. Yes?

Mr. Holloway. I don't argue with you on what you're saying, but we're not talking about football players or us members of congress, we're talking about human lives.

Chairman Miller. No, I understand that, I understand that. But I'm saying, we shouldn't discount the addiction. I have taken friends to the hospital that are bleeding from the nose and the ears from drugs, you know, and they still can't stop.

I've taken people from this body and they couldn't do it, so I think we can't discount the nature of addiction and the behavior. It's not to condone it, it's not to accept it, but I worry that we are in the process of creating more victims in the system.

Mr. Holloway. I think that Mr. Ryan is only trying to say that there is a problem.

Chairman Miller. I'm trying to talk about it generically, I'm not trying to talk about this law, because in some ways this law is far more acceptable than what I see other people trying to do in the name of punishment and in the name of quick solutions.

So, I'm just raising the context of this discussion. I think this committee plans to go into this in even more depth as we look at these alternatives as to how to handle this problem. Henry, welcome to the committee, I'm honored.

Mr. Hyde. Thank you. I simply stopped by because Jim Ryan is my constituent and my neighbor, and he's my dear friend, and we go to church together, of course he stays longer than I do. Anyway, I just wanted to welcome Jim, and I wouldn't presume to intervene other than to say you have one of the most difficult and important problems on the table.

There are no really easy answers, and every case is somewhat different. If there was a treatment that people could take that would work, that would be a miracle, but it's much more complicated than that.

Chairman **MILLER**. Well, thank you. I am going to have to curtail this, I'm sorry, but just let me say that Ms. Kauffman you have raised some very good points and I serve on the Interior Committee in this room, and the Indian Health Service ought to be a place where at least we can try the coordination and delivery of services and reduce the bureaucracy since, no matter what the genesis of the money, it's designed and targeted at a single population.

These arguments between mental health dollars and alcohol and drug dollars really—there's one population where you would think that we would have the ability and I just want to let you know that I think we ought to follow up on much of what you've said here. Because in terms of our grand designs for model programs and everything else, Indian health may be a place where we can look at the kinds of things that many of the previous panel members talked about.

Since it clearly is a targeted population and the notion that we've got to describe you in mental health terms, or dependency terms, or foster care terms to get the dollars, is ridiculous. It's the same damn kid. It just doesn't make any sense. Thank you very much. Thank you for all of your help and your testimony. With that we stand adjourned.

[Whereupon, at 1:50 p.m., the hearing was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF THEDA NEW BREAST, M.P.H., MONTANA BLACKFEET INDIAN

NATIVE AMERICAN WOMEN AND DRUG AND ALCOHOL ISSUES

THE FOLLOWING TESTIMONY IS BY THEDA NEW BREAST, M.P.H., A MONTANA BORN BLACKFEET INDIAN WHO HAS COMPLETED PIONEERING RESEARCH ON THE PREVENTION OF FETAL ALCOHOL SYNDROME AMONG NATIVE AMERICAN WOMEN. IN THE PAST TEN YEARS OF WORKING WITH BOTH ON AND OFF RESERVATION COMMUNITIES, NEW BREAST HAS EXAMINED STRATEGIES TO PREVENT AND INTERVENE AS WELL AS TREAT NATIVE AMERICAN WOMEN WHO ABUSE ALCOHOL AND OTHER DRUGS. CULTURAL COMPETENCY ACROSS THE CONTINUUM OF CARE FOR INDIAN WOMEN IS SEEN AS NECESSARY TO EFFECTIVELY PROVIDE SOLUTION FOR SUBSTANCE ABUSE PROBLEMS.

HIGHLIGHTS OF MY RESEARCH ARE:

SCOPE OF THE PROBLEM

ALCOHOL ABUSE HAS BECOME THE SINGLE HEALTH PROBLEM ACCOUNTING FOR THE FIVE LEADING CAUSES OF DEATH AMONG NATIVE AMERICANS. THE INCIDENCE OF ALCOHOLISM AMONG INDIAN PEOPLE IS ESTIMATED TO BE 5-10 TIMES THAT OF THE GENERAL POPULATION. FEMALES ACCOUNT FOR ALMOST HALF THE TOTAL CIRRHOSIS DEATHS AMONG NATIVE AMERICANS COMPARED TO ONE THIRD FOR WHITE AND BLACK FEMALES. AMONG 15-25 YEARS OLDS, CIRRHOSIS MORTALITY FOR INDIAN FEMALES IS THREE TIMES THAT FOR INDIAN MALES. INDIAN WOMEN 15-34 YEARS OF AGE EXPERIENCE A CIRRHOSIS DEATH RATE THAT IS 37 TIMES THAT FOR WHITE WOMEN OF THE SAME AGE.

THE RESEARCH ALSO TELLS US:

*ONE OUT OF 4 DEATHS FOR NATIVE AMERICAN WOMEN ARE DUE TO CIRRHOSIS IN THE AGES BETWEEN 35 AND 44.

*OVERALL CIRRHOSIS RATES ARE HIGHER FOR NATIVE AMERICAN FEMALES THAN FOR THE WHITE OR BLACK RACES AT EVERY AGE LEVEL.

*RATES OF CIRRHOSIS APPEAR SIGNIFICANTLY AT YOUNGER AGES THAT ANY OTHER ETHNIC GROUPING.

WHAT FACTORS OPERATE IN THE HIGH INCIDENCE OF ALCOHOLISM FOR NATIVE AMERICAN WOMEN

IN THE UNITED STATES TODAY, THERE ARE APPROXIMATELY 2 MILLION PERSONS OF AMERICAN INDIAN DESCENT. HUNDREDS OF FEDERALLY RECOGNIZED TRIBES—OVER 500—REPRESENTING DISTINCT CULTURAL TRADITIONS, DATE BACK EARLY INTO THE HISTORY OF THIS CONTINENT.

LESS THAN HALF OF INDIAN PEOPLE REMAIN ON RESERVATIONS PRIMARILY IN THE MIDWEST, WEST, AND SOUTHWEST; THE MAJORITY OF INDIAN PEOPLE LIVE OFF THE RESERVATION, MOST WHO MIGRATED IN LARGE NUMBERS IN THE 1950's TO METROPOLITAN AREAS IN THE WEST AND MIDWEST.

PATTERNS OF DRINKING AMONG CONTEMPORARY INDIANS IN BOTH GEOGRAPHIC AREAS FOLLOW MANY DIFFERENT PATTERNS; AND THESE VARY AMONG THE TRIBES AND WITHIN THE TRIBES, AS WELL. PLAINS INDIANS ARE HEAVILY IDENTIFIED IN TREATMENT FACILITIES WITH SIOUX WOMEN IN PARTICULAR OFTEN DRINKING AS MUCH OR MORE THAN SIOUX MALES. NAVAJO FEMALES HAVE LONG BEEN NOTED FOR HIGH ABSTINENCE RATES, WHILE NAVAJO MALES HAVE A DOCUMENTED HISTORY OF SIGNIFICANT ALCOHOLISM.

A PREDOMINANT STYLE OF DRINKING ITSELF INCLUDES A FORM OF SHARING OF ALCOHOL AT GATHERINGS AND A PATTERN OF HEAVY DRINKING DURING THOSE OCCASIONS. SOLITARY DRINKING, OFTEN AN INDICATION ALCOHOLIC DRINKING FOR THE DOMINANT SOCIETY IS UNCOMMON FOR BOTH MALE AND FEMALES; FREQUENT BINGE DRINKING WITH COMPANY REMAINS THE NORM.

RESEARCH TODAY INDICATES THAT THE CULTURAL STEREOTYPE OF INDIAN SUSCEPTIBILITY TO ALCOHOL HAS LARGELY BEEN DISAPPROVED. LITTLE EVIDENCE HAS BEEN ISOLATED TO INDICATE A BIOLOGICAL MAKE-UP PREDISPOSING INDIANS TO ALCOHOLISM. RATHER, CULTURAL, SOCIAL AND ECONOMIC FACTORS HAVE COMBINED TO DEVELOP AND INSTITUTIONALIZE ALCOHOL AS A MAJOR SOCIAL COPING CHOICE.

THE CLOSEST THAT CURRENT STUDIES HAVE COME TO IDENTIFYING ANY SPECIFIC NATIVE AMERICAN BIOLOGICAL TRAIT IS AN INDICATION THAT THIS POPULATION METABOLIZES ALCOHOL FASTER THAN THE WHITE RACE. (OTHER ETHNIC MINORITIES, BLACK AND LATINOS HAVE NOT BEEN STUDIED.)

PERHAPS, THE MOST PROMINENT EXPLANATION OF THEORY SPECIFICALLY CONTRIBUTING TO THE WAY IN WHICH NATIVE AMERICANS AND FEMALES ARE SUSCEPTIBLE TO ALCOHOLISM LIES IN THE PSYCHIC ADJUSTMENT TO BATTLING DOMINANT CULTURE THEY DID NOT WANT. THIS ADJUSTMENT CONTINUES TODAY AND PROVIDES SOME OF THE CULTURALLY DISTINCTIVE PATTERNS OF SUSCEPTIBILITY TO DEPRESSION AND FRUSTRATION. WOMEN AS WELL AS MEN IN OUR CULTURE HAVE FOLLOWED THE PATH OF ESCAPISM IN ALCOHOL. DEVELOPING WITHIN THE CONFLICT BETWEEN THE VALUES OF THE TRADITIONAL CULTURE AND THOSE OF THE DOMINANT SOCIETY PLAYS A MAJOR ROLE IN ALCOHOLISM WITH INDIAN COMMUNITIES, URBAN AS WELL AS RURAL.

INDIAN VALUES PLACE DIFFERENT AND SOMETIMES CONFLICTING DEMANDS ON AN INDIVIDUAL. MUCH HAS BEEN STATED ABOUT THE NEED TO LIVE AND PARTICIPATE SUCCESSFULLY WITHIN BOTH CULTURES BUT THE ACHIEVEMENT OF THIS IS DIFFICULT AND DIVIDES NATIVE AMERICANS IN THEIR ABILITIES TO EMOTIONALLY AND SOCIALLY DEAL WITH THIS DUALITY.

NATIVE AMERICAN WOMEN WHO WORK OUTSIDE THE HOME FACE THE SAME STRESSES AND CONFLICT THAT ALL WOMEN FACE IN THE MALE DOMINATED SOCIETY, BUT INDIAN WOMEN FACE A TRIPLE BURDEN. BESIDES BEING FEMALE, CULTURALLY DISPLACED AND OFTEN POOR, THEY MUST ALSO FACE THE PROBLEM OF DISCRIMINATION BY THE DOMINANT CULTURE.

WE HAVE LITTLE SPECIFIC INFORMATION FOR NATIVE AMERICAN WOMEN AND DRINKING SUSCEPTIBILITY, BUT A FAIRLY RECENT ANALYSIS OF DATA BY WALKER(8) AND ROBINSON AT THE UNIVERSITY OF SEATTLE PUBLISHED THAT AMERICAN INDIAN AND ESKIMO WOMEN COMPRISED 20% OF THE WOMEN ADMITTED TO TREATMENT FACILITIES DURING THE SIX-MONTH PERIOD. DIFFERENCES BETWEEN INDIAN AND NON-INDIAN WOMEN WITH DRINKING PROBLEMS WERE FOUND AS FOLLOWS:

*INDIAN WOMEN WERE DIAGNOSED AS ALCOHOLICS AT AN EARLY AGE;
* THEY WERE REARED FEWER YEARS BY THEIR NATURAL PARENTS (DUE IN LARGE PART TO THE TRADITION OF DISPLACEMENT BY BOARDING SCHOOL ENROLLMENT);
*HAD LESS OVERALL SCHOOLING;
*WERE OF LOWER SOCIO-ECONOMIC CLASS; AND
*WERE MORE LIKELY TO HAVE BEEN INCARCERATED AT AN EARLIER AGE.

IT WAS NOTABLE THAT THE INDIAN WOMEN INTERVIEW IN THIS STUDY WERE LESS LIKELY THAN THE CAUCASIAN WOMEN TO HAVE SOUGHT MENTAL HEALTH COUNSELING OR TO HAVE UNDERGONE IN-PATIENT AND/OR OUT-PATIENT TREATMENT FOR EMOTIONAL PROBLEMS OFTEN LINKED TO ALCOHOLISM.

IT IS OFTEN SUSPECTED AND CONFIRMED BY INDIAN WOMEN WHO ARE FIGHTING LONG-TERM EFFECTS OF ALCOHOL ABUSE THAT FEAR OF LOSING THEIR CHILDREN PREVENTS THEM FROM ACCESSING HELP FROM SOCIAL AGENCIES. CONFIRMATION OF THE PRACTICE OF REMOVING, SOMETIMES PERMANENTLY THE CHILDREN HAS NOT BEEN UNCOMMON. WITHIN THE ADVENT OF THE INDIAN CHILD WELFARE ACT, PASSED IN 1978, DUE PROCESS HAS OFFERED TO MANY WOMEN ASSISTANCE IN PLACING CHILDREN TEMPORARILY IN FOSTER CARE OR WITH RELATIVES, ENCOURAGING THEM TO SEEK HELP FOR ADDICTION PROBLEMS.

SOME SITUATIONS THAT TYPICALLY EXIST FOR SOME INDIAN WOMEN ARE:

(1) A LOSS OF FAITH IN THEIR ROLE MODELS AND A DISORIENTATION MAKING THEM MORE VULNERABLE TO BEGIN DRINKING PATTERNS TO RELIEVE OVERALL CULTURAL AND ROLE CONFLICT. FEELINGS OF INFERIORITY ARE OFTEN DESCRIBED IN THEIR RELATIONSHIP TO THE WORLD AROUND THEM, WHETHER ON THE RESERVATION OR WITHIN URBAN AREAS. DRINKING CAN BE OBSERVED IN CULTURAL AND BELIEF ROLE CONFLICTS.

(2) SIMILAR TO MANY WHITE WOMEN, THEY FEEL ISOLATED AT HOME WITH LITTLE MEANINGFUL WORK TO DO; WITH OFTEN AN UNEMPLOYED DRINKING HUSBAND OR PARTNER AND CHILDREN DEMANDING THEIR ATTENTION AND CARE. SHE CAN BECOME A VICTIM OF ALCOHOL AND THE LEGAL/ILLEGAL PRESCRIPTION DRUGS—THE RESPONSE TO ECONOMIC ISSUES, MATERNAL DEPRIVATION AND BOREDOM.

AS WE FIND WITH WOMEN IN GENERAL, THIS SPECIFIC RESPONSE TO SEX-ROLE AND ECONOMIC CONFLICT OFTEN PRODUCES FEELINGS OF POWERLESSNESS AND HELPLESSNESS; INCREASING VULNERABILITY TO ALL OTHER TYPES OF EXPLOITATION FROM RAPE TO WIFE BATTERING AND OTHER FORMS OF SOCIAL AND EMOTIONAL ABUSE.

THE EFFECTS OF ALCOHOLISM REINFORCE A SENSE OF POWERLESSNESS AND WORTH.

SPECIFIC BEHAVIORS AND ATTITUDES OF INDIAN WOMEN WERE RECENTLY STUDIED THAT MAY BE TYPICAL OF INDIAN WOMEN ALCOHOLICS. FROM THE UNIVERSITY OF UTAH GRADUATE SCHOOL OF SOCIAL WORK IN 1985, A MASTER'S THESIS FOCUSED ON A GROUP OF SHOSHONE-BANNOCK WOMEN FROM THE FORT HALL RESERVATION, WHO IDENTIFIED THEMSELVES (OR WERE IDENTIFIED BY OTHERS) AS HAVING SVEVERE PROBLEM DRINKING EPISODES. KEY POINTS:

*NEARLY 80% DRANK TO OVERCOME SHYNESS;
*70% FELT THAT THEIR MARITAL PROBLEMS CAUSED THEM TO DRINK;
*64% BELIEVED THAT THEIR DRINKING HAD BEEN A FACTOR IN MARITAL DIFFICULTIES;
*93% STATED THAT THEY DID NO DRINK ALONE;
*72% REPORTED THAT THEIR HUSBANDS OR BOYFRIENDS DRANK MODERATELY OR QUITE A BIT;
*64% AFFIRMED THAT THEIR DRINKING CAUSED THEM HARDSHIPS WITH FAMILY AND FRIENDS;
*65% EXPERIMENTED BLACKOUT PATTERNS OF DRINKING EPISODES;

*50% REPORTED THEY HAD ATTEMPTED SUICIDE ON ONE TO THREE DIFFERENT OCCASIONS;

*100% SAW ALCOHOL AS A WAY OF HAVING FUN AND GETTING OVER DEPRESSION; AND

*AVERAGE INITIAL AGE FOR INTOXICATION WAS 14.4 YEARS

OVERALL, THE STUDY--ONE OF THE FEW TO IDENTIFY CURRENT PATTERNS OF SELF-CONCEPT AND ATTITUDES--RECOUNTED A CYCLICAL PATTERN: DEPRESSION, FROM ALCOHOL ABUSE TO SUICIDAL BEHAVIOR TO ABSTINENCE RELAPSE AND BACK TO DEPRESSION. IMPLICATION FOR ASSESSMENT AND TREATMENT SUGGEST THAT TO COME TO TERMS WITH THIS SITUATION, THE PATTERN MUST BE BROKEN AND EFFECTIVE CULTURALLY-SENSITIVE TREATMENT MUST BE INITIATED TO DEAL WITH THIS PERSONAL, AS WELL AS CULTURAL GENOCIDE.

TODAY, MANY RECOVERING INDIAN WOMEN, AND THOSE WHO HAVE ABSTAINED FROM ALCOHOL USE, SEE THEIR COLLECTIVE STRENGTH AS A FORCE FOR CHANGE. INDIAN HERITAGE IS ONE IN WHICH POLITICAL POWER AND IMPORTANCE WITHIN THE COMMUNITY WAS HISTORICALLY A WOMAN'S RIGHT NOT ONE RECENTLY GAINED THROUGH SOCIAL EMANCIPATION. (THE WESTERN APACHES, AS WE EXAMPLE, HAVE INCLUDED A HISTORY OF WOMEN CHIEFS.) IN OTHER TRIBES, WOMEN HAVE ALWAYS TRADITIONALLY SPOKEN AT COUNCIL MEETINGS, GIVEN ADVICE ON CHILD CARE AND FAMILY AFFAIRS, AND PERFORMED IMPORTANT SOCIETAL AND SPIRITUAL FUNCTIONS. IN A REPORT ON ALCOHOLISM AMONG NATIVE AMERICAN WOMEN, S. HERNANDEX FROM NEW MEXICO STATED THAT IF WE WERE TO PUT THESES FUNCTIONS INTO MODERN TERMS, WE COULD SAY SHE WAS A SOCIAL WORKER, A FAMILY COUNSELOR, A PEDIATRICIAN, A BUSINESS ADVISOR AND COMMUNITY VOLUNTEER.

INDIAN WOMEN HAVE ALWAYS BEEN SECURE ABOUT THEIR IMPORTANT ROLE WITHIN THEIR FAMILIES AND CULTURE. THEIR STRESS AND SUPPRESSION HAS OFTEN OCCURRED WITHIN THE CONFLICT OF CULTURE BETWEEN CULTURE.

IN A CONFERENCE ADDRESS ON PROBLEMS COMMON TO INDIAN WOMEN, MARY ANN LAVALLEE STATED, "OUR CULTURE UP TO NOW HAS DECREED THAT INDIAN WOMEN ARE A SOURCE OF UNLIMITED POTENTIAL." FOCUSING THIS FEMININE POTENTIAL COULD EXERT A PARTICULAR KIND OF PRESSURE WITHIN THE INDIAN COMMUNITIES, ACROSS ALL TRIBAL AFFILIATIONS, TOWARD HEALING THE INDIVIDUAL AS WELL AS THE CULTURE FRONT THE EPIDEMIC EFFECTS OF ALCOHOLISM, AND ALCOHOL-RELATED PROBLEMS.

CULTURAL SENSITIVITY AND ASSESSMENT:

THE NATIVE AMERICAN WOMAN

A RESPECT AND AN UNDERSTANDING OF THE CLIENT'S CULTURE, ENVIRONMENT, FAMILY AND TRIBAL HISTORY CAN NEVER BE OVERSTATED IN THE ASSESSMENT PROCESS. NO GROUP OF PEOPLE HAVE SUFFERED FROM SUCH CULTURAL GENERALIZATION THAN THE AMERICAN INDIAN AND PARTICULARLY THE AMERICAN INDIAN WOMAN. GIVEN THE VARIETY OF TRIBES, THE GEOGRAPHIC INFLUENCE, RURAL OR URBAN, AND THE DEGREE OF TRADITIONS OBSERVED AND INTERNALIZED BY THE CLIENT, COUPLED WITH THE TRADITIONS OBSERVED BY HER PARTNER OR SPOUSE'S FAMILY, YOU MAY FIND THE ASSESSMENT TASK COMPLICATED. WHAT IS APPROPRIATE FOR A TRADITIONAL FEMALE FROM A MONTANA RESERVATION COULD BE VAGUELY FAMILIAR OR EVEN CONFUSING TO A SECOND GENERATION NATIVE AMERICAN WOMAN FROM LOS ANGELES WHO RARELY VISITS HER TRIBAL HOMELAND. OF IMMENSE HELP IN WORKING WITH THIS CLIENT IS NA UNDERSTANDING OF AN IDENTIFICATION PROCESS CALLED, LEVELS OF TRADITIONAL BEHAVIOR.

A SCREENING SYSTEM CALLED "GENERATION" DEFINES FOUR DIFFERENT CATEGORIES FOR NATIVE AMERICAN CLIENTS.

FIRST GENERATION: THESE INDIVIDUALS LIVE CLOSELY TO TRADITIONAL VALUES OF THEIR TRIBE.

SECOND GENERATION: THESE INDIVIDUALS STILL KEEP A LOT OF TRADITIONS AND CUSTOMS IN THEIR LIVES, BUT MIX IT WITH A BIT OF THE CONTEMPORARY VALUES. THEY ARE SLIGHTLY REMOVED FROM TRADITIONAL ACTIVITIES AND STANDARDS.

THIRD GENERATION: THESE PEOPLE ARE EVEN MORE REMOVED FROM TRADITIONAL VALUES AND STANDARDS. BY CHOICE, THEY LIVE A CONTEMPORARY LIFE, BUT STILL HAVE ACCESS TO THE TRADITIONAL. THEY MAY FREQUENTLY VISIT A FAMILY ON OR NEAR THE RESERVATION OF THEIR PEOPLE.

FOURTH GENERATION: THESE INDIVIDUALS ARE TOTALLY REMOVED FROM TRADITIONAL PEOPLE OR LIFE, EITHER THROUGH CHOICE OR THROUGH CIRCUMSTANCES BEYOND THEIR CONTROL.

GIVEN THE VARIETY OF CULTURAL INFLUENCES, IT IS IMPORTANT TO FURTHER UNDERSTAND THAT THE DECISION TO SEEK HELP IS USUALLY PROMPTED BY THE VERY THING WHICH THREATEN THE WHITE CLIENT: LOSS OF A JOB OR FAMILY, LACK OF FINANCIAL SECURITY, MEDICAL PROBLEMS AND DEEPLY IMPORTANT FOR INDIAN PEOPLE--THE LOSS OF RESPECT FROM PEOPLE WHO ARE CLOSE.

> "THERE IS A STRONG BELIEF THAT THE ALCOHOLIC INDIAN MUST HIT SKID ROW, OR "LOW BOTTOM" WHERE EVERYTHING SHE HOLDS CLOSE-FAMILY, JOB, FRIENDS, ETC., IS GONE...THIS IS A FALSE ASSUMPTION AND MUST BE AVOIDED IN WORKING WITH INDIAN ALCOHOLICS. THIS IDEA IS A DEFEATIST GENERALIZATION WHICH FORCES READY-MADE EXCUSES FOR LONG-TERM CHRONIC DRINKING. THE LOW-BOTTOM DRUNK HAS THE MOST DIFFICULTY BEING MOTIVATED TO SEEK TREATMENT, HIS PROGNOSIS THE POOREST. (E. DANIEL EDWARD, MOTIVATION AND COUNSELING FOR THE INDIAN ALCOHOLIC, ABSTRACT.)"

IF THE APPLICATION OF THE KINDS OF DRINKING WERE APPLIED TO THE STYLE OBSERVED IN THE INDIAN COMMUNITY, YOU MIGHT FIND AN ABSENCE OF THE "SOLITARY" DRINKING STYLE INDICATIVE OF MIDDLE OR LATE STAGES OF THE DISEASE. INDIANS DRINK TOGETHER IN PUBLIC OR DURING CELEBRATIONS (POW-WOW). IT WAS NOT UNTIL THE MID-FIFTIES WHEN NATIVE AMERICANS WERE ALLOWED TO BY LIQUOR OR BE SERVED ALCOHOL IN A BAR: UNTIL THEN IT WAS ILLEGAL.

MANY FEEL THAT 37 YEARS LATER, OLD HABITS DIE HARD. UNDER THOSE PRE-1953 CONDITIONS WHEN ALCOHOL WAS AVAILABLE, IT WAS SHARED IN SECRET AND CONSUMED QUICKLY. TODAY THIS IS STILL REFLECTED IN BOTH THE RURAL AND URBAN INDIAN COMMUNITY DRINKING PATTERNS.

ASSESSMENT

PERHAPS THE MOST DIFFICULT ASPECT OF WORKING WITH NATIVE AMERICAN WOMEN ABOUT A DEEPLY PERSONAL ISSUE SUCH AS THEIR ALCOHOLISM IS DEVELOPING A STYLE WHICH IS HELPFUL AND CULTURALLY SENSITIVE. IF THERE IS LITTLE EMOTION OR AFFECT OR EYE CONTACT BY THE CLIENT THAT MAY BE A REFLECTION OF THE WOMEN'S TRADITIONAL ORIENTATION IF SHE IS NATIVE AMERICAN OR SHE MAYBE SHY- WAIT AND WATCH. ASKING TOO MANY QUESTIONS TOO QUICKLY IS CONSIDERED INTRUSIVE AND RUDE. IT IS BETTER TO SIT COMFORTABLY AND QUIETLY AND TO GENTLY TAKE THE TIME TO ENGAGE IN SMALL TALK OR "VISITING".

JUMPING INTO THE ASSESSMENT. GIVING THE APPEARANCE OF FEELING RUSHED WILL GIVE A MESSAGE OF INSENSITIVITY.

THE ASSESSMENT ITSELF MAY TAKE TWO SESSIONS OR ONE LONG SESSION. THERE IS NEVER ONE STYLE FOR ALL CLIENTS. IF THERE IS A HESITANCY IN SPEAKING, IF YOU FEEL THERE IS MORE TO COME ABOUT THE CRISIS IN THE FAMILY OR THE REPERCUSSIONS OF BOTH HER DRINKING ENCOURAGE HER TO RETURN THE NEXT DAY. A CARING RELATIONSHIP, ONE THAT IS CAREFULLY BUILT THROUGHOUT THE ASSESSMENT PROCESS WILL BEAR FRUIT WHEN THE TREATMENT PLAN AND THE REFERRAL IS MADE.

WITH THE NATIVE AMERICAN FEMALE, SHOWING THAT YOU CONSIDER HER WORTH THE TIME IT TAKES TO COMPLETELY HEAR HER DRINKING PATTERNS AND HER NEEDS IS THE MOST IMPORTANT GESTURE YOU CAN MAKE TO GAIN TRUST AND INVOLVE HER IN THE RECOVERY JOURNEY. THERE ARE NO SHORTCUTS.

THIS IS TRUE FOR NON-INDIAN MINORITY OR A WHITE COUNSELOR. NATIVE AMERICAN PROGRAMS ARE PARTICULARLY SUCCESSFUL WHEN OPERATED BY INDIAN PEOPLE. MANY PROGRAMS WILL ALSO STAFF OTHER MINORITIES, SUCCESS DEPENDING ON THE SKILL AND OPENESS OF THE INDIVIDUAL COUNSELOR. ONE NORTHWESTERN NATIVE AMERICAN OUTPATIENT PROGRAM OBSERVED THAT THEIR WHITE FEMALE COUNSELOR, NEWLY HIRED, FOUND THE STAFF ASSUMING SHE MIGHT HAVE DIFFICULTY WITH TRADITIONAL WOMEN CLIENTS. IT WAS A SURPRISE TO EVERYONE WHEN CLIENTS RETURNED REQUESTING TO SEE HER. TO THE COUNSELOR'S AMAZEMENT AND THE STAFF'S CHAGRIN, THE COUNSELOR (WITH GENERAL GOOD SKILLS) HAD BECAUSE OF HER SHYNESS ABOUT THE UNFAMILIAR AND A FEAR OF SAYING THE "WRONG" THING, KEPT QUIET DURING MOST OF THE INTERVIEW. WHEN THE COUNSELOR WENT ON TO SHARE HER UNFAMILIARITY WITH THE CLIENT'S CUSTOMS, THEY WERE ONLY TOO HAPPY TO ENLIGHTEN HER. IT WAS THE OPENNESS AND HER WILLINGNESS TO HONESTLY REVEAL HERSELF AND THE THE WISH TO UNDERSTAND HER CLIENTS THAT ALLOWED THEM TO FEEL A NEW SENSE OF EMPOWERMENT ABOUT EDUCATING HER.

SUCCESSFUL FACTORS OF TREATMENT:

> "WHEN AN INDIAN WOMAN FEELS GOOD ABOUT HERSELF AND HER FAMILY, THE SENSE OF ISOLATION AND OPPRESSION SURROUNDING SUBSTANCE ABUSE IS NATURALLY REDUCED. (YVETTE JOSEPH)"

GO SLOWLY AND CONTINUE IN TREATMENT TO EVALUATE THE NEEDS OF HER FAMILY AND THOSE SPECIAL STRESSORS... A DRINKING PARTNER, OR OLDER CHILDREN IN THE HOME WITH EMOTIONAL AND EVEN PHYSICAL PROBLEMS. INDIAN WOMEN AT A CULTURALLY SPECIFIC NATIVE AMERICAN IN-PATIENT PROGRAM WHICH INCLUDES CHILDREN IN RESIDENTIAL TREATMENT, ARE OFTEN ADVISED THAT CHILDREN "WILL BE WORSE FOR A TIME", TESTING NEW LIMITS AND NEW LIMIT SETTING IN THE HOME.

CLIENTS WHO HAVE OVERCOME THEIR RESISTANCE TO SOME KIND OF SUPPORT TO MAINTAIN SOBRIETY DURING PREGNANCY WILL BE CONFRONTED WITH:

1. MALE/FEMALE RELATIONSHIPS
2. WORK ROLES
3. LEISURE TIME
4. PARENTING
5. SEXUALITY

SAME-SEX SUPPORT GROUPS OFFER ONE OF THE MOST DRAMATICALLY SUCCESSFUL TOOLS TOWARDS WORKING THROUGH THE VARIETY OF THESE ISSUES CONFRONTING THE ALCOHOLIC WOMAN. IN A STUDY COMPLETED IN LATE 1986, METCALF FOUND IN A STUDY OF CLIENTS FORM THE NATIVE AMERICAN ALCOHOLISM PROGRAM THAT A CLOSED WOMEN'S MEETING WORKED BECAUSE:

1. WOMEN OFTEN DO NOT DEAL WITH THEIR OWN PROBLEMS WHEN MEN ARE AROUND, BUT RATHER TAKE ON THE MEN'S PROBEMS.
2. WOMEN EXPERIENCE TOW FACES-ONE WITH MEN AND THE OTHER WITH WOMEN.
3. GIVEN THE EXTREMELY HIGH STATISTICS OF PHYSICAL AND SEXUAL ABUSE WITH ALCOHOLIC WOMEN, SORTING IN MIXED-SEX GROUPS PROBLEMS OF EMBARRASSMENT AND SHAME ARE DIFFICULT.
4. MOST IMPORTANT FOR PREGNANT WOMEN IS THE OPPORTUNITY TO FULLY INTERACT WITH OTHER WOMN ABOUT THEIR CONCERNS OF THEIR PRESENT AND PAST ROLES AS MOTHERS.
5. IT IS AN OPPORTUNITY TO FREELY DISCUSS CONFLICT ARISING FROM PAST AND PRESENT DESTRUCTIVE RELATIONSHIPS WITH MEN.

ONE GROUP OF RECOVERING INDIAN WOMEN CONTINUED AFTER THEIR GROUP MEETINGS TIN TREATMENT WITH CONTINUED COOPERATIVE EFFORTS WITH CHILD CARE, JOBS, FOOD AND SHELTER RESOURCES, AND TRANSPORTATION TO MEETINGS. SINGLE PARENTING CONCERNS FOR MANY WERE COMMON.

GROUPS WITHIN THE NATIVE AMERICAN TREATMENT STRUCTURE ARE LESS CONFRONTING THAN TYPICAL DOMINANT CULTURE GROUPS IN BOTH IN AND OUT PATIENT SETTINGS.

FOR SOME TRADITIONAL INDIAN WOMEN, CRYING IN A GROUP IS CONSIDERED AN EMBARRASSMENT AND OTHER MEMBERS MAY QUIETLY LOOK AWAY UNTIL SHE HAS ASSUMED SOME SENSE OF CONTROL. FOR THE LESS CULTURALLY SENSITIVE FACILITATORS ENCOURAGING THE RELEASE OF TEARS PRESSING FOR EXPRESSION IS CONSIDERED IMPOLITE ALTHOUGH THE ONLY INDICATION FOR THE COUNSELOR MAYBE HOSTILE SILENCE. IT IS HELPFUL AT THAT MOMENT TO REASSURE THE GROUP MEMBERS THAT IT IS ALRIGHT FOR SOMEONE TO CRY NOW.

SO CLIENTS WILL PREFER TO ENTER DIRECTLY INTO THE A TWELVE-STEP SELF-HELP PROGRAM IN THEIR COMMUNITY AND THIS IS AN EXCELLENT OPPORTUNITY TO SUPPORT SOBRIETY. MANY NATIVE AMERICAN MEETINGS ENCOURAGE ALL FAMILY MEMBERS TO ATTEND AND YOU CAN BE HELPFUL BY ORGANIZING A LIST OF TIMES AND LOCATIONS FOR HER, POINTING OUT THAT EVEN DAILY ATTENDANCE WOULD HELP.

IF THE CLIENT HAS BEEN ISOLATED WITHIN HER HOME AND EXTENDED FAMILY-SOME OF WHO MAYBE ACTIVELY DRINKING-IT IS IMPORTANT TO ENCOURAGE HER TO ALSO UTILISE SOME OUT-PATIENT ACTIVITY IN THE INITIAL STAGES OF RECOVERY. COUNSELING IS NOT IN CONFLICT WITH TWELVE-STEP SELF-HELP PROGRAMS, AND CAN SERVE TO ENHANCE AN EVEN STRONGER FOUNDATION TO PREVENT A RELAPSE AND ENSURE CONTINUED ABSTINENCE.

MANY TREATMENT PROGRAMS WILL UTILIZE SPECIFIC BEHAVIORAL APPROACHES SUCH AS TECHNIQUES OF SOCIAL AND SELF-MANAGEMENT SKILLS AND THOSE PREPARING THE CLIENT TO BEGIN MORE ASSERTIVE BEHAVIOR. MANY OFFER RELAXATION METHODS SUCH AS MUSCULAR ELOCUTION, MEDITATION AND BIO-FEEDBACK. VISITS BY YOU TO REFERRAL AGENCIES WILL GIVE YOU A PERSONAL IDEA OF BOTH THE STAFF AND THE TREATMENT APPROACHES.

THE RECOVERING CLIENT AND THE FAMILY

IT IS PREDICTABLE THAT THE CLIENT WILL INFLUENCE OTHER FAMILY MEMBERS WHO MAYBE UNAWARE OF THEIR CONTRIBUTION OR ENABLING TRAITS WHICH HAVE SUPPORTED THE DISEASE. IT IS RECOMMENDED THAT THE FAMILY BECOME INVOLVED IN ANY OF THE GROUPS OFFERED IN THE TWELVE-STEP SELF-HELP PROGRAMS. SOME OF THE FRUSTRATIONS THE FAMILY ENCOUNTERS IN HER EARLY SOBRIETY MAY INCLUDE FEELING NEGLECTED BY HER CONSTANT ABSENCE ATTENDING MEETINGS AND OUT-PATIENT SUPPORT GROUPS.

RUTH MAXWELL IN BREAKTHROUGH DESCRIBES THAT ONE THE CLIENT IS STABILIZED IN EARLY RECOVERY SHE MAY START FEELING DEPRESSED. "THEY

THEY DON'T ACTUALLY BECOME DEPRESSED. THEY ARE DEPRESSED AND HAVE BEEN FOR YEARS. THEY'VE JUST HIDDEN THEIR SADNESS FROM THEMSELVES WITH DEFENSIVE BEHAVIORS AND NOW THEIR USE OF DEFENSE BECOMES LESS PRONOUNCED, THEIR UNDERLYING SAD FEELINGS COME FORTH." IT IS IMPORTANT FOR THE FAMILY TO LET THEM FEEL THESE SAD FEELINGS, TO ALLOW THEM TO GRIEVE, MAXWELL SUGGESTS. ENORMOUS COURAGE AND A STRONG SUPPORT SYSTEM TO GIVE UP THE OLD BEHAVIOR OF HIDING THEIR FEELINGS IS NECESSARY. PREDICTING THIS ASPECT OF THE STAGES OF RECOVERY IS USEFUL SO THEY HAVE SOME INKLING THAT THIS WILL PASS AND IS A FORM OF HEALING FROM THE DISEASE.

HEALING FROM THIS DISEASE FOR INDIAN WOMEN MANDATES CULTURAL AND SPIRITUAL HEALING. FOR EXAMPLE, A CONTEMPORARY BI-CULTURAL INDIAN WOMAN WAS UNABLE TO "GET SOBER" WITH THE BEST THAT THE BETTY FORD TREATMENT CENTER HAD TO OFFER, BECAUSE IT LACKED A CULTURAL COMPONENT.

[illegible]

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
385 House Office Building Annex 2
Washington, DC 20515

[illegible]

June 18, 1990

Ms. Susan Galbraith, Staff Director
Coalition on Alcohol and Drug
  Dependent Women and Their Children
2057 Park Road, N.W.
Washington, DC 20010

Dear Ms. Galbraith:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Law and Policy Affecting Addicted Women and Their Children" on May 17, 1990. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by June 27 with any necessary corrections. In addition, I am requesting a response in writing to the following question:

> I am very impressed with the list of members in your Coalition on Alcohol and Drug Dependent Women and Their Children. The key recommendation of your coalition seems to be placing real teeth in the 10% set-aside for women's drug treatment in the Alcohol, Drug and ental Health Services Block Grant. What are the top two or three recommendations of the Coalition beyond accountability mechanisms in the set-aside?

Let me again express my thanks, and that of the other members of the Committee for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
     Youth, and Families

Enclosure

RESPONSE TO QUESTION POSED BY CHAIRMAN GEORGE MILLER

Coalition on Alcohol and Drug Dependent Women and Their Children

June 26, 1990

The Honorable George Miller
Chairman
Select Committee on Children,
 Youth and Families
385 House Office Building Annex 2
Washington, D.C. 20515

Dear Congressman Miller:

Enclosed is my marked copy of the transcript from your hearing on "Law and Policy Affecting Addicted Women and Their Children." Thank you again for the opportunity to testify and for your important work on this issue.

Three additional recommendations for enhancing services for pregnant alcoholic and drug dependent women and their children which are supported by the coalition are:

1. Requiring that the definition of services covered for pregnant women under Medicaid include alcoholism and drug dependency residential services for women, their infants and children (our proposal is attached);

2. Authorize and appropriate $20 million to establish a demonstration program through the Indian Health Service to serve pregnant and postpartum Native American women with alcohol and drug problems, their infants and children; and

3. Substantially increase Head Start funding to expand eligibility, attract and retain qualified staff, permit training and enhance services.

I would be happy to provide you with more details on these proposals. Please feel free to call me if you have any questions or if you need additional information.

Sincerely,

Susan Galbraith

Susan Galbraith
Director

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EXPLANATION OF MEDICAID FAMILY CARE ACT PROVIDING MEDICAID COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCY RESIDENTIAL TREATMENT

Section 1 adds alcoholism and drug dependency residential treatment services to the list of services a state must cover for Medicaid-eligible pregnant women.

Section 2 clarifies that alcoholism and drug dependency treatment services must be covered for certain Medicaid-eligible pregnant women (those with family incomes at or below 133% of poverty who are not eligible under another section- such as being an AFDC recipient) as services for conditions which complicate pregnancy. It also exempts residents of treatment facilities (as defined in #6) from the "institution for mental diseases" ("IMD") exclusion.

Section 3 adds alcoholism and drug dependency treatment services as an optional service for Medicaid-eligible caretaker relatives who are not pregnant. Most commonly, this will be a mother with dependent children. This section also exempts this service from the "comparability" requirements so that a state choosing to provide this service to caretaker relatives would not have to provide it to all other Medicaid eligibles.
It also exempts residents of treatment facilities (as defined in #6) from the "institution for mental diseases" ("IMD") exclusion.

Section 4 corrects a technical problem for pregnant women who are Medicaid-eligible only due to their pregnancy and limited income (as opposed to being eligible as an AFDC recipient). Under current law, these women lose their Medicaid eligibility 2 to 3 months after the end of their pregnancy. This section would extend their eligibility to 12 months following the end of their pregnancy. Services covered during this period would continue to be limited to "pregnancy related and postpartum" services which includes alcoholism and drug dependency treatment services. The purpose of extending eligibility is to allow a pregnant woman who enters treatment late in her pregnancy to complete treatment.

Section 5 merely adds alcoholism and drug dependency treatment services to the laundry list of Medicaid services.

Section 6 has three main parts. The first part of section 6 sets out the various services that must be provided by an alcoholism and drug dependency residential treatment facility. It also limits Medicaid coverage to non-profit non-hospital facilities with no greater than 40 beds.

The second part of section 6 requires facilities wishing to get Medicaid reimbursement to be certified by the Alcohol and Drug Abuse Single State Agency as being able to provide the full range of services required. The purpose of this requirement is to help ensure quality of care by having treatment facilities reviewed by the state agency with greatest expertise in alcohol and drug treatment.

The third part of section 6 precludes states from imposing arbitrary restrictions on duration of coverage shorter than 12 months. It does allow states to use prior authorization and utilization review to guard against inappropriate or excessive utilization of residential treatment.

Section 7 requires states to pay residential treatment facilities 100% of their reasonable costs in order to help ensure adequate levels of quality and provider participation. This section uses the provision added by OBRA '89 which currently applies to community and rural health centers.

Section 8 establishes an effective date for these provisions of July 1, 1991, regardless of whether HCFA has promulgated regulations. This date was chosen to correspond with the start of many states' fiscal year and to give adequate lead time to HCFA and the states to set up the administrative structures necessary to carry out these provisions.

MEDICAID FAMILY CARE ACT

PROVIDING MEDICAID COVERAGE OF ALCOHOLISM AND DRUG DEPENDENCY RESIDENTIAL TREATMENT SERVICES FOR PREGNANT WOMEN AND SPECIFIED CARETAKER RELATIVES

PROPOSED LEGISLATIVE LANGUAGE

1. Mandatory coverage of residential treatment for all Medicaid-eligible pregnant women.

Amend section 1902(a)(10)(A) of the Social Security Act [42 USC 1396a(a)(10)(A)] by inserting (portion underlined):

> "For making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1905(a) (and in the case of pregnant women receiving medical assistance under subparts (A)(i), (A)(ii) and (C) of this subsection and pregnant women described in section 1902(l), the services listed in paragraph (23) of section 1905(a)),

2. Mandatory coverage of treatment for pregnant women eligible under the 133% of poverty category.

Amend 1902(a)(10)(E) of the Social Security Act [42 USC 1396a(a)(10)] by inserting [portion underlined]:

> "(VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy including services to treat alcoholism or drug dependency which, notwithstanding the exclusion from coverage for individuals in institutions for mental diseases contained in section 1905(a), shall include alcoholism and drug dependency residential treatment services (as defined in section 1905(t))."

3. Optional coverage of residential treatment for specified caretaker relatives.

Amend 1902(a)(10) [42 USC 1396a(a)(10)] by adding at the end of the sentence following subpart (E):

> "(XII) the medical assistance made available to individuals who are specified relatives as set forth in section 1905(a)(ii) and eligible for medical assistance under subparts (A)(i)(I),(III),(V) or (ii)(I),(II),(III) or (C) of this section, may include alcoholism and drug dependency residential treatment services (as defined in section 1905(t)) notwithstanding the exclusion from coverage for individuals in institutions for mental diseases contained in section 1905(a), without making these services available to other groups covered by the state plan notwithstanding subpart (B) of this subsection."

4. Continuation of eligibility for 12 months following end of pregnancy.

Amend 1902(e) [42 USC 1396a(e)] by inserting [portion underlined]:

> "(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, including services for the treatment of alcoholism and drug dependency for a period of 12 months beginning on the first day of the month following the month in which her pregnancy ends."

Amend 1902(l)(1) [42 USC 1396a(l)(1)] by inserting [portion underlined]:

> "(A) women during pregnancy (and during the 12 month period beginning on the first day of the month following the month in which her pregnancy ends).

5. Listing of residential treatment services.

Amend 1905(a) [42 USC 1396d(a)] by adding subpart (23) as follows:

> "(23) alcoholism and drug dependency residential treatment services (as defined in subsection (t) of this section);"

6. Definition and requirements of residential treatment services.

Amend 1905 (42 USC 1396d) by adding subsection (t) as follows:

"(t)(1) The term 'alcoholism and drug dependency residential treatment services' shall at a minimum include the following services provided either directly or by contract by a non-profit residential treatment facility that is not licensed as a hospital and has no greater than forty beds :

(A) addiction education and treatment services based upon individualized treatment plans;

(B) individual, group and family counseling;

(C) opportunity for involvement in Alcoholics Anonymous, Narcotics Anonymous and other support groups;

(D) for pregnant women, access and referral to prenatal and postpartum health care and family planning services, including where appropriate services provided under Title V of this act (Maternal and Child Health Services Block Grant) and services and nutritional supplements provided under [need cite here] (Women, Infants and Children Program);

(E) room and board for parents and their children (up to age 13), subject to reasonable limitations imposed by the service provider on the number of the children, in a structured, supervised and developmentally appropriate environment;

(F) for parents, parenting skills training and other family support services;

(G) domestic violence and sexual abuse counseling where appropriate;

(H) access to developmental services for pre-school children and public education for school-aged children and parents who have not completed high school including assistance to parents in enrolling their children in school;

(I) access and referral to literacy, vocational and other employment related counseling and training where appropriate;

(J) child care that meets applicable standards of state and local law;

(K) counseling for the children of persons in treatment;

(L) access and referral to other health and social services where appropriate;

(M) reentry counseling and activities;

(N) discharge planning including assistance in obtaining suitable affordable housing and employment upon discharge;

(O) referral to appropriate aftercare upon discharge; and

(P) continuing specialized training for staff in the special needs of residents and their children, designed to enable such staff to stay abreast of the latest and most effective treatment techniques."

"(2) A facility may not receive payment under this Title for providing alcoholism and drug dependency residential treatment services unless the agency designated by the State to administer funds received for alcoholism and drug abuse services under the Alcohol and Drug Abuse and Mental Health Services Block Grant (42 USC 300x et.seq.) has certified to the single State agency (designated pursuant to section 1902(a)(5)) that the facility is able to provide, either directly or by contract, all the services specified in subpart (1) and meets all applicable state licensure or certification requirements."

"(3) To the extent covered under this Title, alcoholism and drug dependency residential treatment services shall be covered under a state plan for such period of time as is medically necessary for each individual receiving or authorized to receive these services. Notwithstanding this requirement, a state plan may limit coverage of alcoholism and drug dependency residential treatment services to a period not less than 12 months. A state may subject alcoholism and drug dependency residential treatment services to prior authorization and utilization review requirements to ensure that services are appropriate and medically necessary."

"(4) Nothing in this subsection shall exclude other alcoholism and drug dependency treatment services from coverage under a state plan to the extent such services may otherwise be covered under this Title."

7. Payment for residential treatment services.

Section 1902(a)(13)(E) [42 USC 1396a(a)(13)(E)] is amended by inserting after "for payment for services described in section 1905(a)(2)(C) under the plan" the following:

",and for payment for services described in subsection (1) of section 1905(t) under the plan,".

8. Effective date.

"Effective date- The amendments made by this section apply to payments under Title XIX of the Social Security Act beginning on July 1, 1991 without regard to whether final regulations to carry out such amendments have been promulgated by such date."

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
[illegible]
WASHINGTON, DC 20515

June 18, 1990

David Gates, J.D.
National Health Law Program
2025 M Street, N.W., Suite 400
Washington, D.C. 20036

Dear Mr. Gates:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Law and Policy Affecting Addicted Women and Their Children" on May 17, 1990. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by June 27 with any necessary corrections. In addition, I am requesting a response in writing to the following questions:

> Have you completed your survey of the 10 states' policies regarding reimbursement for drug treatment through Medicaid? If it is possible at this time, would you briefly summarize your findings?

Let me again express my thanks, and that of the other members of the Committee for your participation.

Sincerely,

George Miller

George Miller
Chairman
Select Committee on Children,
Youth, and Families

Enclosure

[The survey of the 10 States' policies regarding reimbursement for drug treatment through Medicaid is retained in Committee files.]

Prepared Statement of Jill Hiatt and Janet Dinsmore, Senior Attorney and Communications Director, National Center for Prosecution of Child Abuse, Washington, DC

Mr. Chairman and Members of the Select Committee: We appreciate the opportunity to submit testimony on the topic of legal and policy matters affecting drug-dependent mothers. Both of us have long experience as child advocates in the legal arena, as well as working with child welfare, health professionals and family service groups. Jill Hiatt, Senior Attorney at the National Center for Prosecution of Child Abuse, will return to Oakland, California this fall, where she is a Deputy District Attorney for Alameda County, responsible for reviewing some 2400 child abuse cases each year. Janet Dinsmore, Communications Director for the Center, has worked for a variety of children's groups and written extensively on legal and social reform. We commend your tireless leadership on behalf of children, Mr. Chairman, and the major contributions of this Committee to addressing the needs of the most vulnerable in our nation.

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> On Mother's Day a 28 year-old woman stands in a prison hallway holding her child and cries. She is a prisoner and she is having the first visit from her children in 13 months. But the reasons for her tears appear much greater than the visit alone. It is the first time, she says, she can hold her children as a drug-free woman. She credits prison with helping her to "be clean for the first time since I was 13 years old," and says, "it is a blessing for me to be here" (Washington Post, 5/14/90).

With national attention focused on drug use and drug-related crime and violence, few issues provoke more controversy or frustration than substance abuse by pregnant women. There is little dispute over its undesirability or harmfulness--to the woman, the fetus or existing children in the home. But there is intense disagreement over how, when, where and who should attempt to stop it, and whose rights take precedence.

Criminal justice, medical and social service professionals are divided among themselves and each other over how best to respond to maternal drug use. The issue also splits women's and children's advocates--long-time allies on family violence concerns--legislators, treatment providers, and correctional officials, and places traditional opponents such as pro-choice and right-to-life advocates on the same side against prosecution. Opposition to prosecution (or, "punitive measures," as it is euphemistically referred to) seems, in fact, the one area of agreement for many health and women's rights groups. These same individuals define "prosecution" or "punitive measures" as meaning one thing--jail with no treatment and automatic loss of any children involved.

The developing polarization between some women's rights groups and traditional criminal justice approaches to drug dependent women and their drug exposed infants is wasting time, effort and most of all, energy. Facing off against each other instead of standing together for the well-being of drug-impaired women and their children is draining valuable resources society cannot afford to waste at a time when so many lives are being lost or permanently damaged by drug abuse. Fueling the debate are myths about prosecution, myths about treatment, myths about the role of social service agencies, myths about motives and a whole range of genuine problems we should be working to address.

One of the most prevalent myths is that treatment must be voluntary to be effective and that those who abuse drugs would stop doing so if treatment were available. Given the fact that for many drug users, arrest is the precipitating factor for their entry into treatment, this is simply unrealistic. Drug counselors, probation officers, and former addicts readily acknowledge that court supervision is often critical to maintenance in a treatment program. Research confirms that while criminal sanctions ALONE do not reduce drug abuse, "The coercive power, surveillance potential and time offered through criminal sanctions open significant opportunities for effectively treating the cocaine-heroin abuser....There are a variety of pressures that bring hardcore drug abusers into treatment: parents, employers, loved ones and friends may all apply psychological and social pressures. The most powerful pressure, however, may be the threat of legal sanction--the threat of arrest and conviction, and most importantly, the threat of incarceration. The leverage created by this threat, and by the sanction itself, permits treatment to be considered a viable option by serious abusers." (Source: National Institute of Justice, Issues and Practices in Criminal Justice, March 1988)

The fact that treatment counselors, health professionals and former substance abusers acknowledge this fact has not softened the outcry against "punitive measures." Is anyone listening?

Realistically, the only way that answers will be found to the complex questions posed by parental drug use is through understanding and cooperation. To gain that cooperation it may be necessary for social service, women's rights and health groups to look more closely at their prejudices and the power and potential for good that exist with the criminal justice system. At the same time, criminal justice professionals may be called on to lay down their spears and look more carefully at the big picture, to see whether traditional forms of law enforcement can be better shaped to deal with a problem that is both legal and social in nature.

One of the largest and most powerful forces in this country is the criminal justice system. One may decry that fact but it is nonetheless so. Since drug use is against the law--a crime that is neither aggravated nor mitigated by childbearing--the criminal justice system has a powerful tool in its hands. It is time for all concerned groups to find ways of using that tool to deal with a problem that fails to respond to other attempts to ameliorate it.

The perception repeated again and again--that the criminal justice system wants only to punish women by putting them in jail--ignores the reality of the system and stifles the search for solutions. It has also distorted the debate by focusing attention on a tiny fraction of criminal cases involving drug use by pregnant women and child caretakers. Within the criminal justice system's boundaries rest many different means of dealing with crime: probation, diversion, deferred prosecution, treatment in lieu of incarceration, etc. The list of alternatives is long and useful to consider. Much of the outcry against prosecution, however, is rooted in these very few but highly publicized cases involving novel uses of traditional laws to prosecute women who have given birth to drug-affected babies. The best known of those cases, in Sanford, Florida, involved the prosecution of a woman for delivery of drugs to a minor based on the transfer of drugs through the umbilical cord between the time of birth and cutting of the cord. Other cases have involved prosecuting the mother for possession of illegal substances based on the presence of drugs in the baby's system at birth. There have additionally been some attempts to prosecute the mother on a variety of abuse theories based on the condition of the baby at birth resulting from the mothers ingestion of drugs during pregnancy. Few of these cases have proceeded to trial and only one is currently known to be pending appeal.

Most of these prosecutions are the result of medical workers' frustrations over a mother's production of not one but two, three or ten babies born with the kind of damage that makes their initial weeks and months a living hell and, it appears, probably haunt them for the remainder of their lives, if they survive. While some deride the apparently punitive focus of these prosecutions, one wonders if those same detractors truly believe we must wait until society resolves underlying problems such as poverty, discrimination and hopelessness before responding to the current crisis with all the creativity we can muster.

The vast majority of drug-related cases processed by the criminal justice system have nothing to do with pregnancy. Drug crimes, however, bring into the system hundreds of thousands of mothers and fathers whose substance abuse endangers their current and future families. It is on these individuals who are already in the system that we should be concentrating our attention. The potential for making a significant impact in terms of successful drug treatment is truly enormous.

Pregnancy does not excuse criminal behavior but in many cases can be an additional factor in assessing an individual's criminal penalty. The use of diversion for example, has long been a means of dealing with drug addicts as well as other first-time criminal offenders. It is similar to probation in that there are requirements that the diverted individual must fulfill but there need be no conviction. If the individual completes diversion requirements, the case is dismissed. At least two diversion programs in the country have been specifically developed for pregnant drug-abusing women, and include such requirements as regular prenatal care and staying off drugs. One program requires participation in a treatment program, and the other strongly encourages it. While these programs are in the very early stages, they seem to hold promise for wide replication in the future.

Most jurisdictions grant probation in many cases involving pregnant drug abusers. Probation can and should include not only drug treatment but also a requirement that the women participate in a prenatal program that will help keep her and the baby healthy. In some cases when the crime is either so serious or is a repeat offense the court can and often does sentence drug offenders to treatment facilities in lieu of jail. Such sentences can benefit both baby and mother, allowing the baby a drug-free prenatal environment and the hope that the mother will remain drug-free following completion of her sentence.

When all else fails and there is no alternative to incarceration, comprehensive long-term drug treatment in jail or prison should be used. Even here, significant incentives for treatment can be built in through early release programs based on credits earned through participation in drug treatment. The inclusion of such treatment within institutions is becoming more common with the rising recognition of the close relationships between criminal behavior and drug use.

Prosecutors throughout the country acknowledge the lack of effective treatment facilities and in many jurisdictions are working with other agencies to identify funding and comprehensive programs for pregnant addicts. The National Center for Prosecution of Child Abuse receives many calls from prosecutors who are working with task forces made up of health, social service, family court and law enforcement officials to develop services for drug-ravaged families. The National District Attorneys Association (NDAA) has also formally recommended a treatment option for offenders on probation and a method for funding drug abuse education and treatment in its "Proposed Amendments to the Uniform Controlled Substances Act" (UCSA, 1989). NDAA has also proposed in the UCSA a funding mechanism that has raised millions of dollars for drug education and treatment in New Jersey.

There is much discussion of the need for treatment that is accessible, that accepts pregnant women on Medicaid, that offers resources for residential or day care if needed, and that is sensitive to the unique needs of female addicts and women of color. What is missing from the discussion is recognition that many addicts--particularly crack addicts who face a long-term recovery period--find it difficult or impossible to remain drug-free without some outside coercion in addition to extensive support. At a recent meeting of the Coalition on Alcohol and Drug Dependant Women and Their Children, a veteran Philadelphia health worker, Bruni Sepulvada spoke eloquently of the problems she faces in persuading addicts to get into and remain committed to treatment. Despite apparently heroic efforts on the part of her health workers, the work is filled with frustration and failure. One of the bright spots, she said, is a successful "behavior modification" program involving hard-core parolees whose requirements include participation in treatment. Several, she said, have asked to remain under electronic surveillance past their release date, knowing they could resist street pressure to resume drug use only when they and their peers knew they had to answer to the criminal justice system.

This fall, according to the NEW YORK TIMES, 40-60 percent of the children entering kindergarten in some neighborhoods have drug-related problems. Last year's jump in child abuse and neglect reports--reaching an all-time high of 2.4 million--were directly related to parental and caretaker drug use, according to the National Committee for Prevention of Child Abuse. The Committee also reported that child protection agencies were so overwhelmed with cases, only the most severe were being addressed, leaving others to worsen until they too became emergencies.

Alcoholics Anonymous, one of the most respected and successful addiction treatment programs, has said that people do not seek treatment before "hitting bottom." Those who would remove intervention by the criminal justice system as a "bottom" ignore the fact that for many people, the alternative to prison will be the grave. There is no time left to wait for the "hit bottom syndrome" to occur naturally to help save the women and children that drugs are destroying. The criminal justice system, working in partnership with other agencies, has the tools to force the acceptance of treatment now, and ways must be found to work together with rather than against each other.

The woman being visited by her child in prison paid a high price for her habit but the result is beyond value. In exchange for some months in prison, she got back a life, one that had been in limbo for 15 years. Equally important, her children gained a mother they would otherwise never have known. She apparently believes it was well worth the price.

So perhaps it is time for the criminal justice system, social services, and woman's rights groups to sit down and talk, and start acting together on behalf of those who need true advocacy. Only as a joint effort will this tragic problem be solved, and it is one problem we HAVE to solve.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, WASHINGTON, DC

The National Association of Public Hospitals (NAPH) would like to take this opportunity to submit this statement to the House Select Committee on Children, Youth, and Families in connection with the Committee's May 17th hearing on chemically-dependent pregnant women. NAPH consists of over 90 urban public and non-profit hospitals that serve as major referral centers, teaching hospitals, and hospitals of last resort for the poor and medically underserved in most of our nation's largest metropolitan areas. Many of NAPH's hospitals treat a disproportionate share of addicted mothers and their children. As a result of this and other resource demands, many NAPH hospitals are on the edge of financial collapse and in desperate need of increased governmental support.

The consequences of substance abuse among pregnant women are numerous. First, substance-abusing women often lack access to prenatal care or may not seek it. Second, babies exposed to substance abuse are more likely to be born prematurely and have low birth rate, increasing their risk of infant mortality and childhood disability, as well as their need for intensive and expensive hospital care. Third, a drug-exposed baby has a myriad of physical and emotional problems which are particularly stressful to an addicted parent. Each of these problems, directly or indirectly, increases the demand on the U.S. hospital system, especially public hospitals. Without additional government support, our hospitals will be unable to meet this demand.

Unfortunately, information is limited with respect to the magnitude of the substance abuse problem as it impacts hospitals across the country. NAPH, however, recently surveyed 26 member hospitals and identified 2,693 infants exposed to cocaine during 1988. This represents an average of 104 cases per institution. During the first half of 1989, the annualized average increased to 122 cases per institution. It should be noted that very few institutions have universal testing, so in most cases the infants identified are done so by self-reporting by the mother or by testing as a result of infant characteristics and suspected drug use. Nonetheless, the limited NAPH study reveals two disturbing trends. First, utilization of hospital services by drug-exposed infants (and by inference drug-addicted mothers) is increasing at a significant pace. Second, the problem of crack cocaine and other addictive drugs is impacting public hospitals all across the country, not just those in New York and Los Angeles.

To further illustrate these observations, a recent study at Truman Medical Center in Kansas City, Missouri produced startling results. It found that approximately 15% of babies born at Truman Medical Center tested positive for cocaine. For this test to indicate the presence of cocaine, the mother must have utilized "crack" cocaine within a 72-hour period prior to delivery. In the middle of the nation, almost one out of six babies born at the public hospital tested positive for cocaine! Moreover, 1990 birth projections of cocaine-affected infants at Truman already are significantly higher than 1988 statistics.

The plight of the public hospitals cannot be overstated. Trauma centers and emergency rooms are overcrowded to the breaking point. Occupancy rates continue to rise, topping 100 percent in some cities, and critically ill patients wait up to 36 hours for an inpatient bed. Gang violence, AIDS, refugees and other problems are growing at an alarming rate in some cities - greatly compromising their ability to serve less seriously ill indigent patients. Combined with these problems, the additional stress of treating a growing population of substance-abusing mothers and their children has pushed many public hospitals to the brink of financial ruin.

MARYVILLE CITY OF YOUTH

1150 North River Road
Des Plaines, Illinois, 60016
708/824-6126

May 30, 1990

Dr. Carol Statuto
U.S. House of Representatives
Select Committee on Children, Youth & Family
House Office Building
Room 384
Washington, D.C. 20515

Mr. Chairman, and Other Distinguished Members of the Select Committee on Children, Youth & Family:

I am Rev. John P. Smyth, Executive Director of Columbus-Maryville Reception Center, 800 W. Montrose, Chicago, Illinois. I am writing to provide information regarding the children under our care.

Maryville Academy originated in 1883 when the Chicago Fire resulted in hundreds of needy orphans. Since that time, Maryville has treated tens of thousands of Illinois youth who have become wards of the State. Many of our current youth have been the victims of physical, sexual and emotional abuse and neglect. Our "mission" if you will, is to help these children to become successful. They are given a place to sleep, food, clothing, and most important, they are given love, care, and concern - to some, foreign concepts. Maryville currently operates on eight campuses throughout Northern Illinois and Wisconsin. Maryville has assumed the responsibility for hiring, training, and supervising all Center staff. All staff receive extensive training in the Family-Teaching model of child-care with its emphasis on Teaching, Evaluation, and Consultation.

The most recent addition is the Columbus-Maryville Reception Center. This movement permitted the expansion of the former Emergency Service Center for children removed from Cook County homes due to suspected abuse and/or neglect. The Center opened in June of 1988 and is under an operational contract from the Illinois Department of Children and Family Services. Columbus-Maryville has to date treated 7,500 children from newborns to age twenty, and provides emergency protective residential care and medical evaluations. In accord with the IDCFS, we make every attempt to return a child to their natural parents whenever feasibly possible.

Rev. John P. Smyth
Executive Director

Dan L. Ferro
Rev. David P. Ryan
Assistant Executive Directors

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Thomas M. Tully

THE CATHOLIC CHARITIES ARCHDIOCESE OF CHICAGO

Though currently licensed to serve 120 children, we are constantly requested to increase capacity to accommodate the growing numbers of DCFS wards, and drug-addicted newborns. Admission to Columbus-Maryville is open twenty-four hours each day with a no-decline policy. 75% of our admissions are prepared to return home, or be placed into foster care within a forty-eight hour time span.

Some of our neediest admissions are the infants born addicted to cocaine. Currently, we are caring for twenty-one cocaine addicted and four AIDS infected newborns. These infants require more attention and more nurturing than most as they struggle through cocaine withdrawal. At this point, the medical community cannot help them through their fight. Only hugging, feeding and changing will help them in this terrible process. Thanks to the dedication and generosity of our staff and volunteers, these infants undergo a dramatic change in a short time: They begin to enjoy the human touch, to listen to the lullabies that are sung to them. They begin to open up to the world outside of their own pain.

Columbus-Maryville was recently visited by Mr. Ben Wolf, Attorney for the American Civil Liberties Union and by Mr. Ira Schwartz, Director for the Study of Youth Policy at the University of Michigan. Both Mr. Wolf and Mr. Schwartz toured the facility and visited with staff, children, and cocaine babies. Mr. Schwartz expressed a desire that the children, especially the cocaine babies, be placed into foster care immediately. He stated, "We all would want something different (for these children), but Columbus-Maryville is doing the best it can."

My thanks to the committee for allowing me this opportunity to discuss the work done at Columbus-Maryville Reception Center.

Sincerely,

Rev. John P. Smyth

Rev. John P. Smyth
Executive Director

js/cc

Prepared Statement of Benjamin S. Wolf, Director, Children's and Institutionalized Persons Project, Roger Baldwin Foundation of ACLU, Inc., Chicago, IL

The American Civil Liberties Union of Illinois is a statewide organization of approximately 15,000 members dedicated to preserving the Bill of Rights and enforcing laws to protect civil liberties. The ACLU of Illinois and its parent organization, the American Civil Liberties Union, have had a long history of defending the rights of children and families. Attorneys for the Roger Baldwin Foundation of the ACLU, the litigation arm of the ACLU of Illinois, have represented thousands of children who are wards of the state or who are incarcerated in government institutions such as detention centers, shelters and psychiatric hospitals. See, e.g., B.H. v. Johnson, 715 F.Supp. 1387 (N.D. Ill. 1989); A.T. v. County of Cook, 613 F.Supp. 775 (N.D. Ill. 1985).

I am the Director of the Roger Baldwin Foundation's Children's and Institutionalized Person's Project. In that capacity, I represent in federal court class actions the more that 20,000 children in the custody of the Illinois Department of Children and Family Services ("DCFS"). I have reviewed thousands of pages of internal state documents and personally interviewed dozens of foster children, foster parents, birth parents and caseworkers. In my work on behalf of our most powerless citizens, I have come to believe that recent Illinois laws concerning babies who test positive for controlled substances at birth have done little to protect children and may well have caused them considerable harm.

Our new laws permit DCFS and the juvenile courts conclusively to presume that a newborn infant is neglected if his or her "blood or urine contains any amount of a controlled substance...or a metabolite of a controlled substance..." unless the presence of the substance was the result of medical treatment to the mother or the infant. Ill. Rev. Stat., ch. 37, para. 802-3(c)(1989). *See* Ill. Rev. Stat. ch. 23, para 2053 (1989). Our child protection agencies long have had the power to remove children from environments which are harmful to them. *See, e.g.*, Ill. Rev. Stat. ch. 37, para. 802-3(b)(1989). The real problem for some time in Illinois has not been that DCFS and the courts were unable to obtain legal authority to protect those children who were mistreated or neglected by drug abusing mothers, but rather that the state had few services or placements available when it decided that action was needed.

The new statutes have done nothing to address this problem. One local shelter, the Columbus/Maryville Reception Center, for example, now typically has 40-45 babies in its care, some for several months. As the caring and compassionate staff of the facility freely acknowledge, an institution, even a well run one, is not an appropriate place for a baby. Each infant needs to form bonds with a specific person, and they are not likely to develop into healthy adults if they spend their time under the care of people who work in shifts and volunteers who may not return. The life of these infants frequently is one of drift, disruption and pain.

The statutes which require a finding that a newborn infant is neglected solely because of a drug test foster rigid and simplistic stereotypes which disserve the interests of the children. Unquestionably, some mothers with a history of drug use cannot provide a safe, stable home for a baby. Others can provide a suitable environment is spite of their past drug use, frequently with the help of treatment programs and other services, or with the aid of kind relatives willing to assist in child care. DCFS under the prior law needed to investigate and make an individualized decision about the child's environment. Now the law permits a snap judgment and any real investigation can take months, if it happens at all.

The result is tragic. Nearly every infant who is needlessly removed from the home and forced to live in an institution for any extended period of time suffers serious and irreparable harm. Yet this result is fostered by the simplistic approach of new laws supposedly designed to protect children.

As we allege in our pending class action lawsuit against DCFS, B.H. v. Johnson No. 88 C 5599 (N.D. Ill.), the Illinois child welfare system is in a state of collapse. Instead of the twenty to twenty-five cases which national standards recommend, many DCFS caseworkers have caseloads of 60, 80 or even 100. Under these circumstances, the caseworkers cannot even assure that the children in their care are physically safe. Hundreds of children have been abused and neglected in foster care and institutions. Many essential services are not available or have long waiting lists. The current approach which virtually guarantees that the child welfare system will be flooded with newborn infants who test positive for drugs seems counterproductive and cruel when we provide so little for them after we take them from their homes.

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What Does *Webster* Mean?

James Bopp, Jr.
Richard E. Coleson

VOLUME 138, NUMBER 1 NOVEMBER 1989

is still no clear national sentiment in favor of abortion. As a result, the text and history of our Constitution do not support an abortion right, but the post-Civil War amendments and the Constitution's history do substantiate racial minorities' right to equal protection. Therefore, the demise of abortion rights poses no threat to civil rights in general.

3. Pregnant Women Will Retain Reasonable Liberty Beyond the Abortion Context.

The final alarm that abortion proponents raise is that the Supreme Court's approval of the Missouri Preamble[64] and the demise of *Roe* will restrict pregnant women's liberty. This claim is as unfounded as the rest.

Abortion advocates see no middle way, only the extremes. Either every case is decided in favor of the mother or every case is

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PITT. L. REV. 359, 389 & n.195 (1979) (noting that the more populous states had prohibited abortion by the start of the Civil War); Quay, *Justifiable Abortion—Medical and Legal Foundations*, 49 GEO. L.J. 395, 435 (1961) (identifying Connecticut as the first state to criminalize abortion by statute, in 1821); Witherspoon, *Reexamining Roe: Nineteenth-Century Abortion Statutes and the Fourteenth Amendment*, 17 ST. MARY'S L.J. 29, 33 (1985) (noting that thirty of the thirty-seven states had anti-abortion statutes by the year of the fourteenth amendment).

[64] The Missouri preamble reads:

> 1.205 LIFE BEGINS AT CONCEPTION- UNBORN CHILD DEFINED- FAILURE TO PROVIDE PRENATAL CARE, NO CAUSE OF ACTION FOR
>
> 1. The General Assembly of this state finds that:
>
> (1) The life of each human being begins at conception;
>
> (2) Unborn children have protectable interests in life, health, and well-being;
>
> (3) The natural parents of unborn children have protectable interests in life, health, and well-being of their unborn child.
>
> 2. Effective January 1, 1988, the laws of this state shall be interpreted and construed to acknowledge on behalf of the unborn child at every stage of development, all the rights, privileges, and immunities available to other persons, citizens, and residents of this state, subject only to the Constitution of the United States, and decisional interpretations thereof by the United States Supreme Court and specific provisions to the contrary in the statutes and provisions of this state.
>
> 3. As used in this section, the term "UNBORN CHILDREN" or "UNBORN CHILD" shall include all unborn child or children or the offspring of human beings from the moment of conception until birth at every stage of biological development.
>
> 4. Nothing in this section shall be interpreted as creating a cause of action against a woman for indirectly harming her unborn child by failing to properly care for herself or by failing to follow any particular program of prenatal care.

MO. ANN. STAT. § 1.205 (Vernon 1989).

resolved in favor of the unborn child. Yet Missouri's Preamble is not the first recognition of the unborn's rights, and the courts previously have balanced the rights of both the mother and her child when they conflict.

Some believe that recognizing the unborn's rights will result in extreme restrictions on pregnant women's liberty. These people argue that we are on a slippery slope.[65] They view the matter as one in which the rights of only one party may be considered so that, in their view, any consideration of fetal rights terminates maternal rights. They project onto pro-life advocates this same mindset, claiming that pro-life proponents believe that the unborn child's rights must always prevail. Such a view, however, is not well-founded.

B. *Protection of Fetal Rights Is Nothing New*

Courts have long recognized fetal rights in several areas of the law, including the criminal, property, tort, wrongful death, and equity realms, increasingly so with the rise of modern scientific understanding of prenatal development and the obligation to prevent handicaps for those who will be born.[66]

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[65] *See, e.g.*, Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1994 (1986) ("[C]ourt ordered cesareans may start us down that 'slippery slope' toward controlling and coercing pregnant women in the name of fetal well-being"); Gallagher, *Prenatal Invasions and Interventions: What's Wrong With Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 45 (1987) (" 'The slippery slope' of the threats posed by the fetal rights proposals are no longer hypothetical.").

One commentator observes that even though "claims of slippery slope effect will not necessarily be invalid," they may be "wildly exaggerated." He adds that "slippery slope claims deserve to be viewed skeptically, and the proponent of such a claim must be expected to provide the necessary empirical support." Schauer, *Slippery Slopes*, 99 HARV. L. REV. 361, 382 (1985).

[66] *See, e.g.*, Bopp & Coleson, *supra* note 5, at 246-83; Note, *The Law and the Unborn Child: The Legal and Logical Inconsistencies*, 46 NOTRE DAME L. REV. 349 (1971) (examining the right of the unborn in the context of property, torts, equity, criminal, and abortion law). As many commentators have noted, *Roe*'s declaration that the unborn have no rights of personhood under the fourteenth amendment has been given a broad reading which is unwarranted; *Roe* did not eliminate the rights of the unborn in other contexts. *See* Baron, "*If You Prick Us, Do We Not Bleed?:*" *Of Shylock, Fetuses, and the Concept of Person in the Law*, 11 LAW, MED. & HEALTH CARE 52, 56 (1983) ("[T]he law has been largely willing to confer personhood upon the unborn when solid policy considerations have suggested that course."); Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?*, 23 DUQ. L. REV. 1, 15 (1984); Parness & Pritchard, *To Be Or Not to Be: Protecting the Unborn Potentiality of Life*, 51 U. CIN. L. REV. 257, 258 (1982); Note, *Unborn Child: Can You Be Protected?*, 22 U. RICH. L. REV. 285, 287 (1988) (*Roe* does not necessarily imply that the state may not grant legal recognition to the unborn in non-fourteenth amendment cases).

Courts have even required mothers to perform or permit certain actions for the protection of the unborn and her own health. With advances in fetal therapy[67] and the increasing recognition of prenatal torts, the invocation of courts' equitable powers to protect the unborn was a logical next step. Moreover, the practice of protecting the unborn from preventable handicaps antedates *Roe* and despite some courts' confusion,[68] *Roe*[69] should not affect it.

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[67] *See, e.g.*, Lenow, *The Fetus as a Patient: Emerging Rights as a Person?*, 9 Am. J.L. & Med. 1, 28 (1983) (stating that "[t]he advent of fetal surgery techniques requires parents, physicians and the legal system to confront the question of how to determine the rights of the unborn fetal patient").

[68] Some courts have misapplied *Roe*'s viability line and have refused to protect pre-viable children. In fact, a majority of courts that have intervened have done so on behalf of the "viable" fetus. One notable exception is Taft v. Taft, 388 Mass. 331, 446 N.E.2d 395 (1983), where the court left open the possibility that "in some situations . . . the State's interest . . . might be sufficiently compelling" to order a pregnant woman to have medical treatment to protect a pre-viable fetus. *Id.* at 334, 446 N.E.2d at 397. However, with a majority of the Justices on the Supreme Court recognizing that the states have a compelling interest in unborn life throughout pregnancy, the viable/pre-viable distinction should be eliminated. If protection of the unborn was proper under *Roe*, it is *a fortiori* proper after the demise of *Roe*.

[69] *Roe*'s holding that the unborn are not fourteenth amendment persons is inapplicable in any other context. *See* Bopp & Coleson, *supra* note 5, at 253-61. In fact, *Roe* has been used to support intervention on behalf of the unborn where the mother chooses not to abort because of its recognition of an "important and legitimate interest in protecting the potentiality of human life" throughout pregnancy. *Roe*, 410 U.S. at 162. *Roe* may, therefore, be viewed as a legitimization of fetal rights and state authority to protect them. *See, e.g.*, Dougherty, *The Right to Begin Life with Sound Body and Mind: Fetal Patients and Conflicts with Their Mothers*, 63 U. Det. L. Rev. 89, 104 (1985) ("[T]he other side of *Roe* is the establishment of the state's compelling interest in protecting viable fetal life"); Myers, *supra* note 66, at 18 ("*Roe* makes clear that the state has a substantial authority to protect fetal life"); Note, *supra* note 66, at 288 (*Roe* "legitimized the state's interest in protecting the potential life of the unborn").

Myers extends the logic of *Roe* to its inescapable conclusion:

> The state's interest in viable fetal life permits it to forbid abortion, an act designed to extinguish life. It follows from this that the state is empowered to proscribe other acts calculated or likely to lead to the same result. Furthermore, since the interest in preservation of fetal life authorizes intervention to prevent destructive acts, it should also authorize limited compulsion of action which is necessary to preserve fetal life. Since a failure to act can as surely lead to frustration of the state's interest as an affirmative act, the underlying interest must reach both cases. . . . Since the state may proscribe acts leading to fetal death, and may, as a result, require birth, its interest in potential life should extend to the protection of the quality of life.

Myers, *supra* note 66, at 18-19 (citations omitted). One commentator has even suggested that as viability is pushed back, "*Roe* soon may become a 'right-to-life' decision." Rhoden, *The New Neonatal Dilemma: Live Births from Late Abortions*, 72 Geo. L.J. 1451, 1454 (1984).

Several examples demonstrate ways in which the courts have acted to protect the unborn from harm caused by actions of their mothers. In *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*,[70] the New Jersey Supreme Court granted an order compelling blood transfusions, despite the mother's religious convictions, to save her 32-week-old unborn child. The court observed that without the transfusions "both she [the mother] and the unborn child will die,"[71] and held that the unborn child's right to life outweighed the mother's religious beliefs.[72]

The courts also have allowed more intrusive procedures like caesarian sections. In 1981, the Georgia Supreme Court granted an order compelling a caesarian section over a woman's religious objections because a vaginal delivery endangered both her life and the child's.[73] In other cases, reported[74] and unreported,[75] the trend toward court ordered caesarian section to protect the unborn from harm continues.

Finally, courts have also acted to protect the unborn from a class of maternal actions which will lead to serious fetal damage. The concept of preventing avoidable prenatal injuries has strong support. In

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[70] 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

[71] *Id.* at 423, 201 A.2d at 538.

[72] *See id.* at 424, 201 A.2d at 538; *see also* Crouse Irving Memorial Hosp., Inc. v. Paddock, 127 Misc. 2d 101, 485 N.Y.S.2d 443 (N.Y. Sup. Ct. 1985) (ordering blood transfusions to save a mother and child over the mother and father's religious objections); *In Re* Application of Jamaica Hosp., 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985) (ordering blood transfusion to save an 18-week-old fetus over maternal religious objections).

[73] *See* Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457 (1981). The mother in *Jefferson* had a condition known as complete placenta previa (blockage of the birth canal by the placenta). Evidence before the court revealed a vaginal birth would pose a 50% risk of death to the mother and a 99% risk for the child. Prior to the caesarian section, the condition corrected itself, which is rare, and the woman delivered normally. *See also* Lenow, *supra* note 67, at 21 n.123.

[74] *See, e.g.*, *In re* A.C., 533 A.2d 611, 611 (D.C. 1987), *vacated and reh'g en banc granted*, 539 A.2d 203 (D.C. 1988) (holding that a hospital could perform a caesarian section on a terminally ill woman despite her objections).

[75] *See, e.g.*, Jurow & Paul, *Cesarean Delivery for Fetal Distress Without Maternal Consent*, 63 OBSTET. & GYN. 596 (1984) (discussing a case where doctors delivered a fetally distressed infant by cesarian section against the mother's wishes and without a court order); Kolder, Gallagher & Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1197 (1987) (noting a national survey counting instances of court appointed obstetrical procedures in cases of women refusing treatment necessary to preserve the health of the fetus); Watson & Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 AM. J. OBSTET. & GYN. 209, 212 (1981) (discussing *In re* Unborn Baby Kenner, No. 79JN83 (Col. Juv. Ct., Mar. 6, 1979), where doctors performed a court ordered caesarian section to safeguard an unborn infant's life in spite of the mother's objections).

1960, the New Jersey Supreme Court declared "that a child has a legal right to begin life with a sound mind and body."[76] With the rapid advance of medical technology, certain prenatal ailments have become treatable in utero[77] and the fetus has become the "second patient."[78] While some commentators have opposed court protection of the unborn in such a situation,[79] there is a shift in attitudes which favors balancing fetal rights with the mother's.[80] This change appears even among pro-choice advocates[81] and, as noted, the courts have already engaged in such balancing.

This action is appropriate.[82] It makes no sense that a person should endure lifetime suffering because her mother cared nothing for the welfare of her child. The cases clearly show that courts will regulate activities that pose a substantial risk of significant harm to the unborn child, provided that the court can reasonably accommodate the mother's health, liberty, and bodily integrity interests.

The extreme results predicted by those asserting an absolute right for the woman[83] are not evident in the cases. *Stallman v. Youngquist*[84] explodes the myth that the courts will allow either children to sue their mothers for negligence, or others to sue for miscarriage. In *Stallman*, the Illinois Supreme Court held that an unborn child injured in an automobile accident, but subsequently borne alive, could not sue her mother.

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[76] Smith v. Brennan, 31 N.J. 353, 364, 157 A.2d 497, 503 (1960).

[77] *See* Harrison, Golbus & Filly, *Management of the Fetus With a Correctable Congenital Defect,* 246 J.A.M.A. 774, 776 (1981).

[78] WILLIAMS OBSTETRICS vii (J. Pritchard & P. MacDonald eds. 16th ed. 1980); *See also* Kolder, Gallagher & Parsons, *supra* note 75, at 1194 (noting that gynecologists and obstetricians take into account the therapeutic interests of the fetus when faced with a mother who refuses fetal therapy).

[79] *See, e.g.*, Gallagher, *supra* note 65.

[80] *Compare* Fletcher, *The Fetus as Patient: Ethical Issues,* 246 J.A.M.A. 772, 772 (1981) ("As long as the fetus is not separate from the mother, choices about treatment ought to be made only with her informed consent.") *with* Fletcher, *Ethical Considerations in and Beyond Experimental Fetal Therapy,* 9 SEMINARS IN PERINATOLOGY 130, 134 (1985) ("If the intervention may serve the future infant [with minimal maternal intrusion], the refusal of the mother . . . should not be a final barrier to [treatment].").

[81] *See* Robertson, *Procreative Liberty and the Control of Conception, Pregnancy and Childbirth,* 69 VA. L. REV. 405 (1983). Professor Robertson states: "The maternal-fetal conflicts that arise in managing pregnancy do not involve the woman's right to procreate, but rather her right to bodily integrity *in the course of* procreating. . . . Once she decides to forego abortion and the state chooses to protect the fetus, the woman loses the liberty to act in ways that would adversely affect the fetus." *Id.* at 437. *See also* the comments of Harvard Law School Professor Alan Dershowitz, disputing his colleague Lawrence Tribe, in Dershowitz, *Pro-choice argument goes too far,* Boston Herald, May 16, 1989, at 27, col. 1 ("Once a woman has made the decision to bear a child, the rights of the child should be taken into consideration. . . . [I]t does not follow, as a matter of constitutionality, principle of common sense, that a woman has the right to inflict a lifetime of suffering on her future child, simply in order to satisfy a momentary whim for a quick fix.").

[82] Even John Stuart Mill, that ubiquitous authority in treatises on bioethics and medico-legal matters, wrote that the maximum individual freedom he championed should be limited where one's rights collide with the rights of another. *See* J. MILL, ON LIBERTY 69-70 (G. Himmelfarb ed. 1985).

Thus, although courts will consider the right of a child to be born with a sound mind and body, they show no indication of disregarding the rights and interests of the mother as well. The notion that recognizing fetal rights portends police raids to remove pregnant women from the ski slopes, mandatory genetic testing, or even forced abortions is not borne out by reality.[85]

C. *How the Balancing May be Improved*

Examining the cases demonstrates that to this point, the courts have engaged in an ad hoc analysis. A rule to guide judicial intervention, however, may be derived.

Because the rights and interests of the mother and child are inextricably intertwined prior to birth, the analysis considers both and excludes neither. This principle is foundational in our rule-of-law regime. One's rights are properly limited where they interfere with those of another. Abandoning this egalitarian approach would return us to a class system and grossly undercut our principle of equal justice under the law.

A balancing approach would protect pregnant women's rights just as it protects rights in other areas of law. When we prohibit yelling "Fire!" in a crowded theater, we do not take away the right to free speech. Rather, we curtail the right because it is outweighed by rights and interests of others, found to be more weighty in that case. Therefore, the only equitable approach to considering the rights and interests of both the mother and her child is to balance them.

The result is a spectrum of instances in which at one end, the interests of the mother outweigh those of the unborn child, and at the other, the unborn child must be protected.[86]

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[83] *See* Interview with Laurence Tribe, *Morning Edition*, National Public Radio, July 14, 1989, *quoted in* Do Pregnant Women Lose Legal Rights?, Congressional Quarterly's Editorial Research Reports 44 (July 28, 1989) (positing that women might be punished for athletic activity).

[84] 531 N.E.2d 355 (Ill. 1988).

[85] *See* Do Pregnant Women Lose Legal Rights?, *supra* note 83, at 422-24 (quoting certain persons positing these two extremes as legitimate risks of recognizing fetal rights).

A two-pronged analysis is appropriate for determining when and how the court should act when a conflict of rights occurs.[87]

The first prong of the test may be stated thus: The court may act if the pregnant woman is engaging in knowing and intentional behavior which poses a substantial risk of significant harm to her unborn child, provided that the woman's liberty, health, and bodily integrity interests may reasonably be accommodated.

The purpose of this first prong is twofold. First, the court must examine the risk of harm to the unborn child to determine whether protective action is warranted. Second, if the risk of harm is serious enough to warrant protection, then the court must determine whether this protection can be achieved with a reasonable accommodation of the mother's interests in liberty, bodily integrity, and health. If both cannot be met, a court should not act.

The risk of harm is determined by considering both the substantiality of the risk and the significance of the harm. Where either is very low, there will be a low risk of harm.

For example, activities such as jaywalking pose a risk of significant harm to the unborn child, but the risk itself is slight. Therefore, a court should not intervene. At the other end of the spectrum would be activities such as chronic and severe substance abuse, posing near-certain risk of significant harm.[88] In such situations, a court may act provided that it may make a reasonable accommodation of the mother's interests.

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[86] As a preliminary matter, a court's jurisdiction over the mother and her unborn child must attach from some source. For example, a state statute prohibiting child abuse, or probation from a pre-existing criminal conviction could provide the basis for the court's power over the mother. Further, the state's power could only be properly exercised after proving the facts to be used in balancing these rights in a particular case, pursuant to proper procedures.

[87] The following test assumes a high degree of medical certainty and efficacy for any proposed procedure when medical treatment is sought against the mother's will. There are also other additional considerations:

> State intervention to protect fetal health should be considered only when (1) there is a high likelihood of serious fetal disease, (2) there is a high level of diagnostic and prognostic accuracy, (3) there is strong scientific evidence that the proposed treatment is efficacious, (4) deferring intervention until after birth could cause significant further damage, (5) the risk to the mother is minimal, (6) interference with maternal privacy is not egregious, and (7) attempts at persuasion, education, and obtaining informed consent have been exhausted.

Landwirth, *Fetal Abuse and Neglect: An Emerging Controversy*, 79 PEDIATRICS 508, 513 (1987).

[88] Where the well-being of the mother is also at risk, the state has an additional interest at stake, especially if the harmful activity is criminal.

A reasonable accommodation of the mother's interests must consider the risk to the child together with the risk to and intrusiveness upon the mother that the protective procedure or action requires. A court will determine the degree of risk to and intrusiveness upon the mother by considering the risk to the mother's health, the physical discomfort and intrusiveness of any procedure, and the limitation on her liberty. Where there is a very high risk of harm to or intrusiveness upon the mother, no risk of harm to the child would justify state protective action for the child. Such would be the case where the mother's life is at risk from the protective action. Where the risk of harm to or intrusiveness upon the mother is low and the risk of harm to the child is high, however, protective action would be appropriate.

Where the state is justified in acting, it should act within the guidelines of the second prong of the test: in acting, the state must utilize the least restrictive means necessary to protect the life and health of the unborn.

Because the purpose of enforcement is protective, not punitive, ex post facto penalties would have little value. By the time penalties could be imposed, the damage to the unborn would already have been done. For example, the threat of additional penalties will not deter a woman who is already abusing drugs and engaging in other illegal activity to support her habit, and they will not protect her unborn child.

Further, court fashioned remedies protecting unborn life should be the most minimally intrusive possible. If periodic testing and counseling for substance abuse, in the context of probation for prior abuse, would be effective, then incarceration should be avoided. Other "least restrictive" means of furthering the state's interest in protecting the unborn from harm might include required warnings on alcoholic beverages and public education campaigns about the dangers drugs and alcohol pose to unborn children.

In the end, though, there is no logical or legal reason why a state may not go beyond public education measures to prevent activities which impose substantial risk of significant harm on the unborn. The state, however, must do so in a way that honors the interest of the woman in liberty, health, and bodily integrity.

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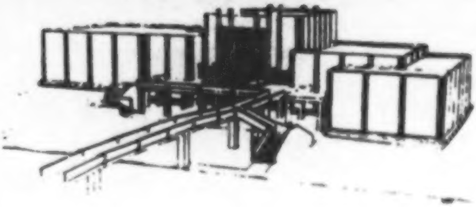

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Volume 3 Number 2

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B. *Fetal Rights in Legal Contexts Other Than Abortion Law*

The anomalies of abortion jurisprudence may also be seen by a comparison of the rights of the unborn in abortion law with their rights in other legal contexts. Before reviewing fetal rights in these other contexts, here is a brief criticism of the legal status of fetal life which *Roe* perpetuated.

The Court referred to the legal status of fetal life in three contexts: (1) An inconclusive history of the legal treatment of the fetus,[456] (2) A discussion of personhood in the Constitution,[457] and (3) An analysis of the legitimate state interest in protecting "potential" life.[458] Subsequent Supreme Court opinions concerning the legal status of fetal life in any of the three contexts have not been rigorously principled. Nor have they adequately given effect to that legal interest especially given the extent to which fetal rights are protected in tort, property and criminal law.[459] Furthermore, despite having imposed national guidelines on abortion, the Court has brought no rationality to laws regulating treatment of the fetus. On the contrary, it has made a consistent and principled policy of protecting unborn life almost impossible. The Court has quite possibly aborted the nascent trend toward legal recognition of the dignity of unborn life. As Justice O'Connor has argued, the treatment accorded fetal life in abortion jurisprudence is illogical[460] since the state's interest in

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442 U.S. 584 (1979), the Court rejected a district court's holding that an adversarial, judicial-type hearing was required by due process for parental commitment of minor children to mental institutions. *Id.* at 607. The Court noted that such a hearing to challenge the parent's decision posed a danger of "significant intrusion into the parent-child relationship." *Id.* at 610. The Court added: "Pitting the parents and child as adversaries often will be at odds with the presumption that parents act in the best interests of their child." *Id.* This presumption seems non-existent in abortion cases.

Finally, the contrast is also observable in Bowen v. American Hosp. Ass'n, 476 U.S. 610 (1986), in which the Court repeatedly referred to decisions for nontreatment by parents of handicapped newborns. *Id.* at 631-39. The Court evinced no concern over the right of parents to make such nontreatment decisions. *Id.* at 636 n.22. The notion of leaving the matter in the parents' hands, without governmental intrusion, underlay the whole opinion.

Although such a "laissez-faire" approach is inappropriate in cases such as Bloomington's Baby Doe, because human life is at risk, the Court finds it appropriate. But, when parents might select a "nontreatment" of the pregnancy of their minor child, believing it to be in her best interest, the privacy right of parents to rear their own children is no longer compelling. Even notifying the parents may be taboo, because parents who may be trusted to have their children's best interests at heart when deciding that they should not receive neonatal surgery, or when committing them to a mental institution, suddenly lose their competency to determine best interest when the subject is abortion.

[456] *Roe*, 410 U.S. at 159-62.

[457] *Id.* at 156-59.

[458] *Id.* at 154, 159, 165.

[459] *See infra* section III-B-1, 2, & 3.

[460] *Akron*, 462 U.S. at 459 (O'Connor, J., dissenting)

protecting life exists throughout pregnancy.[461]

Back, then, to a discussion of fetal rights in other legal contexts. Not only is abortion jurisprudence internally incoherent in regard to the protection of fetal life, it is inconsistent with related areas of law as well. In these related areas fetal rights are given greater protection. Some jurisdictions even recognize pre-conception torts as well as the more usual variety of prenatal harms and interests. Although criminal and tort protection of the fetus is inadequate,[462] the protection of "potential" life in the abortion context seems uninformed by the protection offered in these related areas.[463]

1. Fetal rights in tort law

The law of torts has seen a dramatic change in the past ninety years. The rights of the unborn child have moved from a position of little legal protection to a position where even preconception wrongs are recompensible. As duties to the fetus increase, the foundation upon which *Roe* sits erodes, turning it into the exception rather than the rule in defining the personhood of the fetus.

The first American case which dealt with fetal injury was the celebrated opinion by then Judge Oliver Wendell Holmes, Jr. in *Dietrich v. Northampton.*[464] Holmes interpreted the Massachusetts wrongful death act to preclude recovery for the death of a four to five month old fetus.[465] He held that "the unborn child was a part of the mother at the time of injury" and that "any damage to [the fetus] which was not too remote to be recovered for at all was recoverable by her."[466] *Dietrich* was widely followed by other courts until 1946.[467] Holmes' approach was buttressed by concern with problems of proving causation, and fear that allowing recovery would lead to fictitious claims.[468]

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[461] *Id.* at 459, 460 (O'Connor, J., dissenting).

[462] Parness, *Crimes Against the Unborn: Protecting and Respecting the Potentiality of Human Life*, 22 Harv. J. on Legis. 97 (1985).

[463] *Roe* is sometimes read by lower court judges (and legislatures, too, no doubt) to preclude protection of fetal life, not just prior to viability but in a variety of criminal law contexts as well. For example, some courts have concluded that *Roe* makes feticide during the first three months of pregnancy unpunishable. Another struck down a statute requiring disposal of fetal remains "in a manner consistent with . . . other human remains" because, it reasoned, *Roe* does not permit the treatment of a fetus as a human being in any context. Margaret S. v. Edwards, 488 F. Supp. 181, 221 (E.D. La. 1980)(striking La.Rev.Stat.Ann. § 40:1299.35.14 (1977)).

[464] 138 Mass. 14 (1884).

[465] The fetus lived for "ten or fifteen minutes" after premature birth. *Dietrich*, 138 Mass. at 15. Nevertheless, the court referred to the newborn as an "unborn child." *Id.* at 17.

[466] *Id.* at 17.

[467] Prosser and Keeton on the Law of Torts 367 (W. Keeton ed. 5th ed. 1984).

[468] *Id. See, e.g.*, Magnolia Coca Cola Bottling Co. v. Jordan, 124 Tex. 347, 78 S.W.2d 944 (1935).

Dietrich did not go uncriticized, however. In 1900, the Supreme Court of Illinois followed the reasoning of *Dietrich* in *Allaire v. St. Luke's Hospital.*[469] Justice Boggs issued a strong dissent, attacking the idea that the fetus was a part of the mother:

> Medical science and skill and experience have demonstrated that at a period of gestation in advance of the period of parturition the foetus is capable of independent and separate life, and that though within the body of the mother it is not merely a part of her body, for her body may die in all of its parts and the child remain alive and capable of maintaining life when separated from the dead body of the mother.[470]

Though medical knowledge of the separateness of the fetus from the mother was recognized at the turn of the century, the tort-related legal rights of the unborn were slow in coming.

Recovery for prenatal injuries was finally allowed in 1946, in what William Prosser called "the most spectacular abrupt reversal of a well settled rule in the whole history of the law of torts."[471] In *Bonbrest v. Kotz,*[472] a federal court allowed the plaintiff infant to recover for injuries sustained when he was negligently taken, as a viable fetus, from his mother's womb by the defendant doctor.[473] The reasoning in *Bonbrest* (which closely followed that of Justice Boggs in his earlier dissent) stated:

> As to the viable child being 'part' of its mother—this argument seems to me to be a contradiction in terms. True, it is in the womb, but it is capable now of extrauterine life—and while dependent for its continued development on sustenance derived from its peculiar relationship to its mother, it is not a 'part' of the mother in the sense of a constituent element—as that term is generally understood. Modern medicine is replete with cases of living children being taken from dead mothers. Indeed, apart from viability, a non-viable foetus is not part of its mother.[474]

As to the difficulty of proof of such claims, the court stated: "The law is presumed to keep pace with the sciences and medical science certainly has made progress since 1884. We are concerned here only with the right and not its implementation."[475]

Since *Bonbrest,* every state has recognized prenatal harm as a legitimate cause of action for a child subsequently born.[476] Compensation for prenatal injuries has also been allowed under the Federal Tort Claims Act in an action against the United States.[477] Some states limit recovery to post-viability injuries, but the clear trend is toward recovery for all prenatal harm.[478]

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[469] 184 Ill. 359, 56 N.E. 638 (1900).

[470] *Id.* at 370, 56 N.E. at 641.

[471] W. PROSSER, HANDBOOK ON THE LAW OF TORTS 336 (4th ed. 1971).

[472] 65 F. Supp. 138 (D.D.C. 1946).

[473] *Id.* at 143.

[474] *Id.* at 140.

[475] *Id.* at 143.

The justifications given for discarding the viability test vary. In *Smith v. Brennan*,[479] the New Jersey Supreme Court found that age is not the only determinant of viability, and, in borderline cases, there is no principled way to determine viability.[480] The court said:

> We see no reason for denying recovery for a prenatal injury because it occurred before the infant was capable of separate existence. Whether viable or not at the time of the injury, the child sustains the same harm after birth and therefore, should be given the same opportunity for redress.[481]

A New York appellate court in *Kelly v. Gregory*[482] (the first court to reject the viability standard) focused on the issue of biological separability: "[L]egal separability should begin where there is biological separability."[483] Here, as in other related areas of the law, medical science empowered the engine for legal change. The court noted such knowledge, especially that dealing with fetal development, as a factor in helping to lead to this rule.[484]

The Supreme Court of Rhode Island has dropped the viability test in favor of a causation test: "With us the test will not be viability but causation, and our inquiry will be whether the damage sustained is traceable to the wrongful act of another."[485] This causation test seems more rational and logical than a viability test, which has been criticized as arbitrary and transient.[486] The disallowance of claims for injuries in the first trimester may well be the denial of the most meritorious and seriously harmful claims.[487] Though causation may be difficult to determine, most courts seem to realize that such difficulty should not be a bar to the action, but something to be handled in the courtroom. Recent medical advances make proof of medical causation increasingly reliable.[488]

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[476] Prosser and Keeton, *supra* note 467, at 368.

[477] Sox v. United States, 187 F. Supp. 465 (E.D.S.C. 1960). A cause of action for prenatal injuries under 42 U.S.C. § 1983 (1976) was recognized in Douglas v. Town of Hartford, 542 F. Supp. 1267 (D. Conn. 1982). The Court held that, for purposes of § 1983, a fetus was a "person" within the meaning of the statute. *Contra* Harman v. Daniels, 525 F. Supp. 798 (W.D. Va. 1981)(decided on virtually identical facts); Poole v. Endsley, 371 F. Supp. 1379 (N.D. Fla 1974), *aff'd in part*, 516 F.2d 898 (5th Cir. 1975); McGarvey v. Magee-Womens Hosp., 340 F. Supp. 751 (W.D. Pa. 1972), *aff'd*, 474 F.2d 1339 (3d Cir. 1973). *See generally* Note, *Douglas v. Town of Hartford: The Fetus as Plaintiff Under Section 1983*, 35 Ala. L. Rev. 397 (1984); Note, *The Fetus Under Section 1983: Still Struggling for Recognition*, 34 Syracuse L. Rev. 1029 (1983).

[478] Prosser and Keeton, *supra* note 467, at 368-69; Note, *The Law and the Unborn Child: The Legal and Logical Inconsistencies*, 46 Notre Dame Law. 349, 357 (1970).

[479] 31 N.J. 353, 157 A.2d 497 (1960).

[480] *Id.* at 367, 157 A.2d at 504.

[481] *Id.*

[482] 282 A.D. 542, 125 N.Y.S.2d 696 (1953).

[483] *Id.* at 543, 125 N.Y.S.2d at 697.

[484] *Id.* at 543-44, 125 N.Y.S.2d at 697-98.

[485] Sylvia v. Gobeille, 101 R.I. 76, 79, 220 A.2d 222, 224 (1966).

2. *Fetal rights in wrongful death actions*

Under the language of most wrongful death statutes, recovery is only possible if the death was suffered by a "person."[489] Since wrongful death is a statutory right, the nature of the right depends on the provisions in the individual statutes. Most of the statutes are death acts which create a new cause of action for the death of a person "in favor of a representative and for the benefit of certain designated persons."[490] Other statutes are survival acts which preserve a cause of action for "damages resulting from the victim's death as well as damages accrued at the moment he died."[491] These survival acts allow suits to be brought by the executor or administrator of the decedent's estate.[492] States have both wrongful death and survival provisions, usually encoded in the same statutes.[493]

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[486] *See, e.g.*, Morrison, *Torts Involving the Unborn—A Limited Cosmology*, 31 Baylor L. Rev. 131, 141-44 (1979); Robertson, *Toward Rational Boundaries of Tort Liability for Injury to the Unborn: Prenatal Injuries, Preconception Injuries and Wrongful Life*, 1978 Duke L.J. 1401, 1414-20.

[487] Gordon, *The Unborn Plaintiff*, 63 Mich. L. Rev. 579, 589 (1965).

[488] Prosser and Keeton, *supra* note 467, at 369. In the parent-child relationship, there has been substantial limitation on tort liability. Generally, an unemancipated minor child is immune from tort liability for injury to his parents. *See generally* 67A C.J.S. *Parent & Child* (1978). § 128. In addition, an unemancipated minor child has no right of action against a parent for the tort of the parent. *Id.* at § 129; Annot., *Liability of Parent for Injury to Unemancipated Child Caused by Parent's Negligence—Modern Cases*, 6 A.L.R.4th 1066 (1981)(hereinafter *Liability of Parent*). This intra-family immunity has been justified by the necessity for the protection of family peace and tranquility and by the concern that any change in the rule would interfere with the rights and obligations of parents with respect to the discipline, control, and care of their children. *Id.* at 1072. Some courts, however, have abrogated the intra-family tort immunity doctrine to allow a child to maintain an action against his parents for ordinary negligence, except where the alleged negligent act involves an exercise of parental authority over the child or where it involves an exercise of reasonable parental discretion with regard to the provision of food, clothing, housing, medical and dental care. *Id.* at 1113. *See, e.g.*, Plumley v. Klein, 388 Mich. 1, 199 N.W.2d 169 (1972). In 1980, a Michigan court of appeals, in *Grodin v. Grodin*, indicated a woman would be liable to a child for taking medicine while pregnant which caused the child's teeth to be discolored. 102 Mich. App. 396, 301 N.W.2d 869. Whether the Michigan holding is followed or not, it is apparent that the unborn have strong and increasing rights in tort law. In the tort category of wrongful death actions the same trend may be seen. *See infra*.

[489] Kader, *The Law of Tortious Prenatal Death Since Roe v. Wade*, 45 Mo. L. Rev. 639, 656 (1980).

[490] Prosser and Keeton, *supra* note 467, at 946.

[491] *Id.*

Courts generally allow recovery under the wrongful death statutes where a viable unborn child is injured, born alive, and then dies.[494] This also seems to be the case for nonviable unborn children who are born alive and then die.[495] The Supreme Judicial Court of Massachusetts, in *Torigian v. Watertown News Co.*,[496] allowed recovery on behalf of an infant who died two and a half hours after birth as a result of injuries sustained in the fourth month of gestation. The court reasoned that there was no sound distinction between the viable and nonviable situations, and that the "vast majority" of cases allowed tort recovery to children who were injured when nonviable.[497] The child was held to be a "person" within the meaning of the Wrongful Death Act.[498] The Supreme Court of Alabama, in *Wolfe v. Isbell*,[499] granted an action to a nonviable child who was subsequently born alive and lived for fifty minutes. On the viability question, the court cited approvingly a Wisconsin Supreme Court holding:

> [A] child is no more a part of its mother before it becomes viable that [sic] it is after viability, and . . . it would be more accurate to say that the fetus from conception lived within its mother rather than as a part of her.[500]

The court then reasoned:

> It follows that the right to maintain an action for the wrongful death of an unborn child depends on the right of the particular child, if he had survived, to maintain an action for injuries sustained.[501]

A significant development in this area of tort law was the evolution of the right to maintain a wrongful death action where the injured child was stillborn. The first case to allow such an action, *Verkennes v.*

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[492] *Id.* at 947.

[493] *Id.* at 950.

[494] Kader, *supra* note 489, at 642; Note, *Tort Recovery for the Unborn*, 15 J. FAM. L. 276, 285 (1976-77); Note, *supra* note 478, at 358.

[495] PROSSER AND KEETON, *supra* note 467, at 368-69 ("[W]hen actually faced with the issue for decision, most courts have allowed recovery, even . . . when the child was neither viable nor quick.").

[496] 352 Mass. 446, 225 N.E.2d 926 (1967).

[497] *Id.* at 448, 225 N.E.2d at 927.

[498] *Id.*

[499] 291 Ala. 327, 280 So. 2d 758 (1973).

[500] *Id.* at 331, 280 So. 2d at 761 (citing Puhl v. Milwaukee Auto Ins., 8 Wis. 2d 343, 99 N.W.2d 163 (1959)).

[501] *Id.* at 330, 280 So. 2d at 761.

Cornisa,[502] held that because the unborn were persons a wrongful death claim would be allowed.[503] Later courts have concurred, adding other justifications to this fundamental legal conclusion such as the biological independence of the fetus,[504] as well as the need to effect the remedial and policy purposes of the legislation.[505] An argument made by the Ohio Supreme Court demonstrates a typical attack on the logic of the born-alive rule:

> Suppose . . . viable unborn twins suffered simultaneously the same prenatal injury of which one died before and the other after birth. Shall there be a cause of action for the death of the one and not for that of the other? Surely logic requires recognition of causes of action for the deaths of both, or for neither.[506]

In *Summerfield v. Superior Court,*[507] a 1985 case allowing recovery for a stillborn viable fetus, the Arizona Supreme Court noted a number of reasons for overturning its previous holding which disallowed such actions. The court cited the medical evidence of the separate existence of mother and fetus, as well as the strong legislative policy of protecting the unborn child, as evidenced in the criminal code and property law of the state.[508] The court also noted that the overwhelming majority of jurisdictions allowed a cause of action for the stillborn viable fetus.[509] In 1985, Pennsylvania also joined the ranks of jurisdictions allowing recovery for a stillborn, viable fetus,[510] as did South Dakota,[511] in 1986, and North Carolina, in 1987.[512]

Montana, in 1984,[513] and Texas, in 1987,[514] each disallowed a cause of action for wrongful death of a stillborn child. The Montana

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502. 229 Minn. 365, 38 N.W.2d 838 (1949).

503. *Id.* at 366, 371, 38 N.W.2d at 839, 841.

504. Kader, *supra* note 489, at 646 & n.29. *E.g.*, O'Neill v. Morse, 385 Mich. 130, 135, 188 N.W.2d 785, 787 (1971). *Cf.* Williams v. Marion Rapid Transit, 152 Ohio St. 114, 124, 87 N.E.2d 334, 340 (1949)(holding contra to *Roe* that biological independence compels the conclusion that a fetus is a person).

505. *See* Eich v. Town of Gulf Shores, 293 Ala. 95, 99, 300 So. 2d 354, 356 (1974).

506. Stidam v. Ashmore, 109 Ohio App. 431, 434, 167 N.E.2d 106, 108 (1959).

507. 144 Ariz. 467, 698 P.2d 712 (1985)(en banc).

508. *Id.* at 476, 698 P.2d at 721.

509. *Id.* at 476 & n.5, 698 P.2d at 721-22 & n.5. *Cf.* Tebbutt v. Virostek, 65 N.Y.2d 931, 937-38 n.3, 483 N.E.2d 1142, 1147 n.3 (1985)(Jasen, J., dissenting)("The commentators on the subject of death actions for unborn children are virtually unanimous in favor . . . .").

510. Amadio v. Levin, 509 Pa. 199, 501 A.2d 1085 (1985).

511. Farley v. Mount Marty Hosp., 387 N.W.2d 42 (S.D. 1986).

512. DiDonato v. Wortman, 320 N.C. 423, 358 S.E.2d 489 (1987); *see generally* Comment, *Wrong Without a Remedy—North Carolina and the Wrongful Death of a Stillborn*, 9 CAMPBELL L. REV. 93 (1986).

513. Kuhnke v. Fisher, 210 Mont. 114, 683 P.2d 916 (1984).

514. Witty v. American Gen. Capital Distribs., 727 S.W.2d 503 (Tex. 1987).

court held the legislature had occupied the field by defining a minor child as beginning at birth. Therefore, an unborn fetus could not be a minor child and could not fall within the statute.[515] The Montana Supreme Court noted, "That there is a field here in which the legislature should act [to allow such actions] is beyond question."[516]

The Texas decision declared the issue to be one of legislative intent and held that legislative silence on the matter indicated no intent to include stillborn children within the state wrongful death statute.[517] It also interpreted Texas precedent to require a born-alive rule.[518]

In a powerful, cogent dissent, three members of the Texas Supreme Court rejected the majority's rationale. The dissent declared that the precedent, on which the majority relied for a born-alive rule, was incorrectly interpreted.[519] In prior cases the court had "consistently accepted" its "responsibility to interpret statutes" to prevent inequity, even absent expressed legislative intent.[520] The dissent also noted there was no expressed legislative intent *excluding* fetuses from the statute,[521] and that there were several precedents, both in Texas law and general common law, for including the unborn within the wrongful death statute.[522]

The current number of jurisdictions allowing a cause of action for the wrongful death of a fetus is thirty-six, while those not recognizing such an action are eight.[523] *Roe* has influenced many of these decisions, often with confusing and contradictory results. First, courts have used *Roe* to support the argument that there should be no recovery because the fetus is not a person within the fourteenth amendment. Second, *Roe* has been cited for the proposition that viability is the point where the state interest becomes compelling and, therefore, the statute should apply only at viability. Finally, *Roe* has been cited as supporting the state interest in prenatal life, thereby supporting extension of the wrongful death action to cover the unborn.[524]

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[515] *Kuhnke*, 210 Mont. at 120, 683 P.2d at 919.

[516] *Id.*

[517] *Witty*, 727 S.W.2d at 505.

[518] *Id.* at 505-06.

[519] *Id.* at 507 (Kilgarin, J., dissenting). The debated precedent, Yandell v. Delgado, 471 S.W.2d 569 (Tex. 1971), dealt with the sole issue of "whether a fetus had to be viable at the time an injury was sustained in order for the injury to be actionable." *Witty*, 727 S.W.2d at 507 (Kilgarin, J., dissenting). "Furthermore, in *Yandell*, the fetus survived and the suit was brought for personal injuries, not wrongful death. The live birth issue in a wrongful death context could not have been before the *Yandell* court because there was no death involved." *Id.* at 507-08 (citation omitted). The majority cited *Yandell* as authority for a born-alive rule. *Id.* at 505-06.

[520] *Witty*, 727 S.W.2d at 507, 511-12 (Kilgarin, J., dissenting). The dissent cited several such cases involving the Texas wrongful death statute. *Id.* at 507.

[521] *Id.*

[522] *Id.* at 508-11. A prior decision had reserved the very issue in this case. *Id.* at 510.

[523] Thirty-six jurisdictions recognize a cause of action for the wrongful death of a stillborn child. Eich v. Town of Gulf Shores, 293 Ala. 95, 300 So. 2d 354 (1974); Summerfield v. Superior Ct., 144 Ariz. 467, 698 P.2d 712 (1985)(en banc); Hatala v. Markiewicz, 26 Conn. Supp. 358, 224 A.2d 406 (1966); Worgan v. Greggo & Ferrara, Inc., 50 Del. 258, 128 A.2d 557 (1956); Greater Southeast Community Hosp. v. Williams, 482 A.2d 394 (D.C. 1984); Porter v. Lassiter, 91 Ga. App. 712, 87 S.E.2d 100 (1955); Volk v. Baldazo, 103 Idaho 570, 651 P.2d 11 (1982); Chrisafogeorgis v. Brandenberg, 55 Ill. 2d 368, 304 N.E.2d 88 (1973); Britt v. Sears, 150 Ind. App. 487, 277 N.E.2d 20 (1971); Dunn v. Rose Way, Inc., 333 N.W.2d 830 (Iowa 1983); Hale v. Manion, 189 Kan. 143, 368 P.2d 1 (1962); Mitchell v. Couch, 285 S.W.2d 901 (Ky. 1955); Danos v. St. Pierre, 402 So. 2d 633 (La. 1981); State *ex rel.* Odham v. Sherman, 234 Md. 179, 198 A.2d

Actually, only one sentence and a footnote in *Roe* apply directly. Justice Blackmun wrote: "In a recent development, generally opposed by the commentators, some States permit the parents of a stillborn child to maintain an action for wrongful death because of prenatal injuries."[525] The footnote referred to only two commentators: a note in No-

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71 (1964); Mone v. Greyhound Lines, 368 Mass. 354, 331 N.E.2d 916 (1975); O'Neill v. Morse, 385 Mich. 130, 188 N.W.2d 785 (1971); Verkennes v. Corniea, 229 Minn. 365, 38 N.W.2d 838 (1949); Rainey v. Horn, 221 Miss. 269, 72 So. 2d 434 (1954); O'Grady v. Brown, 654 S.W.2d 904 (Mo. 1983)(en banc); White v. Yup, 85 Nev. 527, 458 P.2d 617 (1969); Poliquin v. MacDonald, 101 N.H. 104, 135 A.2d 249 (1957); Salazar v. St. Vincent Hosp., 95 N.M. 150, 619 P.2d 826 (Ct. App. 1980); DiDonato v. Wortman 320 N.C. 423, 358 S.E.2d 489 (1987); Hopkins v. McBane, 359 N.W.2d 862 (N.D. 1984); Werling v. Sandy, 17 Ohio St. 3d 45, 476 N.E.2d 1053 (1985); Evans v. Olson, 550 P.2d 924 (Okla. 1976); Libbee v. Permanente Clinic, 268 Or. 258, 518 P.2d 636 (1974)(en banc); Amadio v. Levin, 509 Pa. 199, 501 A.2d 1085 (1985); Presley v. Newport Hosp., 117 R.I. 177, 365 A.2d 748 (1976); Fowler v. Woodward, 244 S.C. 608, 138 S.E.2d 42 (1964); Farley v. Mount Marty Hosp., 387 N.W.2d 42 (S.D. 1986)(applying S.D. CODIFIED LAWS ANN. § 21-5-1 (1985 Supp.) which expressly includes a fetus); TENN. CODE ANN. § 20-5-106 (1980)(legislatively overruling Hanby v. McDaniel, 559 S.W.2d 774 (Tenn. 1977)); Vaillancourt v. Medical Center Hosp., 139 Vt. 138, 425 A.2d 92 (1980); Moen v. Hanson, 85 Wash. 2d 597, 537 P.2d 266 (1975)(en banc); Baldwin v. Butcher, 155 W. Va. 431, 184 S.E.2d 428 (1971); Kwaterski v. State Farm Mut. Auto Ins., 34 Wis. 2d 14, 148 N.W.2d 107 (1967).

Eight jurisdictions deny recovery for the wrongful death of a stillborn child. Justus v. Atchison, 19 Cal. 3d 564, 565 P.2d 122, 139 Cal. Rptr. 97 (1977)(en banc); Hernandez v. Garwood, 390 So. 2d 357 (Fla. 1980); Kuhnke v. Fisher, 210 Mont. 114, 683 P.2d 916 (1984); Smith v. Columbus Community Hosp., 222 Neb. 776, 387 N.W.2d 490 (1986); Graf v. Taggert, 43 N.J. 303, 204 A.2d 140 (1964); Tebbutt v. Virostek, 65 N.Y.2d 931, 483 N.E.2d 1142 (1985)(citing with approval Endresz v. Friedberg, 24 N.Y.2d 478, 248 N.E.2d 901, 301 N.Y.S.2d 65 (1969)); Witty v. American Gen. Capital Distribs., 727 S.W.2d 503 (Tex. 1987); Lawrence v. [illegible] Tire Co., 210 Va. 138, 169 S.E.2d 440 (1969).

The Supreme Court of Utah stated, in dictum, that "the death of a viable fetus should be considered as much a ground for damages as would a miscarriage." Nelson v. Peterson, 542 P.2d 1075, 1077 (Utah 1975). Though it cited a 1942 case stating there was no wrongful death cause of action for a fetus, since the issue was moot, it declined to reconsider the issue, saying, "Whether or not [death of a viable fetus] gives a different basis for recovery [from causing a miscarriage] can be determined when liability has been found in a proper case." *Id.* at 1077-78. A federal district court in the Virgin Islands has reportedly upheld a cause of action for wrongful death of a viable, unborn child. Recent Cases, LEX VITAE, Spring, 1987, at 2 (citing Maynard v. Maynard, (D.V.I. May, 1987)). The authors have been unable to obtain a copy of the opinion or locate it on any database.

[524] Kader, *supra* note 489, at 652.

[525] *Roe*, 410 U.S. at 162.

TRE DAME LAWYER and Prosser's treatise on torts.[526] The former did not oppose recovery for wrongful death but opposed abortion as inconsistent with the rights of the unborn, including the wrongful death action which it supported.[527] In fact, the NOTRE DAME LAWYER article declared:

> The law of torts provides even more striking examples. Will the pregnant woman who is hit by a negligent driver while she is on her way to the hospital to have an abortion still have a cause of action for the wrongful death of her unborn child? If so, how is it possible for the law to say that a child can be wrongfully killed only hours before he can be rightfully killed? Absurd as it may seem, this is the present state of the law in some jurisdictions, and it does no good to say that the inconsistencies can be abated simply by refusing all recovery for prenatal injury or death because negligent death or injury to a child whose mother does not want an abortion clearly is a recognizable wrong for which there must be just compensation.
>
> Is the unborn child any less a person when, instead of being killed by an automobile, he is killed by a doctor in the performance of an abortion? Seldom has the law been confronted by such an obvious contradiction.[528]

The other reference in the *Roe* footnote, to Prosser, was apparently in error as well.[529] Prosser simply stated the development of the law, and in no way opposed recovery.[530] Footnotes to Prosser's text did indicate some disagreement, but here even Prosser was in error. He implied that some articles opposed recovery for stillborns when they did not,[531] and he omitted several articles and the key material cited in *Verkennes v. Corniea* which favored recovery.[532] The Supreme Court also overlooked persuasive arguments and the clear trend of cases between 1971 (the date of Prosser's work) and 1973 (the date of *Roe*).[533]

Thus, *Roe's* discussion of wrongful death actions for unborn children was "largely inaccurate, and should not be relied upon as the correct view of the law at the time of *Roe v. Wade*."[534] Despite this fact and *Roe's* silence as to whether such actions for wrongful death were consistent with the abortion ruling, some cases have mentioned *Roe* in examining or re-examining the question of recovery for the wrongful death of a stillborn fetus. Interestingly, some have done so with no mention of *Roe*.

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[526] *Id.* at 162 n.65.

[527] Note, *supra* note 478.

[528] *Id.* at 369.

[529] Kader, *supra* note 489, at 653.

[530] W. Prosser, *supra* note 471, at 338.

[531] Kader, *supra* note 489, at 654-55.

[532] 229 Minn. at 370, 38 N.W.2d at 841. Kader, *supra* note 489, at 654-55.

[533] Kader, *supra* note 489, at 654-56. Four of the five cases decided in this period favored recognizing the cause of action. *Id.*

[534] *Id.* at 653.

For those states denying recovery for the unborn in wrongful death actions, *Roe* has been seen as supportive authority. In *Justus v. Atchison*,[535] the California Supreme Court said it was "not so naive" as to believe the legislature could have entertained any idea of the fetus as a person when the wrongful death acts were passed in 1862 and 1872.[536] This was a clear reference to *Roe's* finding of no personhood for the fetus in the fourteenth amendment, which arose in the same time period.[537] Of such circular logic, Kader made the following observation:

> There is a certain circularity in all of this, perhaps inevitable. *Roe v. Wade* relie[d] upon nineteenth century legislation for evidence that the fetus was not considered nor intended to be a "person" in the law, and modern prenatal death decisions in turn cite the conclusion of *Roe v. Wade* for the same proposition.[538]

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[535] 19 Cal. 3d 564, 565 P.2d 122, 139 Cal. Rptr. 97 (1977)(en banc).

[536] *Id.* at 571, 565 P.2d at 132, 139 Cal. Rptr. at 101.

[537] *Roe*, 410 U.S. at 158.

[538] Kader, *supra* note 489, at 658. Ironically, it is precisely during this period that science was recognizing that fetuses were fully human from conception. As Victor Rosenblum has observed:

> Only in the second quarter of the nineteenth century did biological research advance to the extent of understanding the actual mechanism of human reproduction and of what truly comprised the onset of gestational development. The nineteenth century saw a gradual but profoundly influential revolution in the scientific understanding of the beginning of individual mammalian life. Although sperm had been discovered in 1677, the mammalian egg was not identified until 1827. The cell was first recognized as the structural unit of organisms in 1839, and the egg and sperm were recognized as cells in the next two decades. These developments were brought to the attention of the American state legislatures and public by those professionals most familiar with their unfolding import—physicians. It was the new research findings which persuaded doctors that the old "quickening" distinction embodied in the common and some statutory law was unscientific and indefensible.

The Human Life Bill: Hearings on S. 158 Before the Subcomm. on Separation of Powers of the Senate Comm. on the Judiciary, 97th Cong., 1st Sess. 474 (statement of Victor Rosenblum, Professor of Law and Political Science, Northwestern Univ.); *see also*, Dellapenna, *supra* note 430, at 402-04. About 1857, the American Medical Association led a "physicians' crusade" to enact legislation to protect the unborn from conception. J. MOHR, *supra* note 425, at 147-70. The resulting legislation was designed primarily to protect the unborn and not, as Justice Blackmun claimed, solely to protect maternal health. *Id.*, *See Roe*, 410 U.S. at 151 & n.48. Contrary to Justice Blackmun's assertion, eleven state decisions explicitly affirmed protection of the unborn child as a purpose of their abortion statute (nineteenth century), and nine others implied the same. Gorby, *The "Right" to an Abortion, the Scope of Fourteenth Amendment "Personhood," and the Supreme Court's Birth Requirement*, 1979 S. ILL. U.L.J. 1, 16-17. Furthermore, twenty-six of thirty-six had laws against abortion by the end of the Civil War, as did six of the ten territories by 1865. Dellapenna, *supra* note 430, at 429. This flatly contradicts Justice Blackmun's statement that such legislation did not become widespread until after the Civil War. *Roe*, 410 U.S. at 139.

The California Supreme Court also cited *Roe* as authority for the nonpersonhood of the unborn.[539] The court noted that any change must come from the legislature, which had occupied the field.[540] California appellate courts had rejected the cause of action before *Roe* was decided, so *Roe* was used to support pre-established California law.[541] The *Justus* opinion figured prominently in the recent rejection of a wrongful death action for the unborn in Texas.[542]

Roe also influenced the Florida Supreme Court in the 1980 case of *Hernandez v. Garwood.*[543] The court cited *Roe* as authority that a fetus was not a person and that equal protection of the fetus was not violated if it were excluded from the wrongful death act unless born alive.[544] There was no Florida rejection of the cause of action for stillborns before *Roe*. In 1977, the Florida Supreme Court first refused the cause of action in *Stern v. Miller.*[545] It noted that a change must be made by the legislature, since legislative intent was the issue.[546] However, the court noted that the weight of authority favored the cause of action, the reasons were "compelling," and the commentators "sp[oke] in one accord . . . and urge[d] recovery."[547] No reference to *Roe* was made in the *Stern* opinion, nor in a brief opinion affirming it in 1978.[548] However, the attitude shifted, as noted, in *Hernandez* with an explicit reliance on *Roe*.

Tennessee also denied a cause of action in wrongful death actions for the unborn. It had denied the action before *Roe* in 1958, stating that the fetus was not a person.[549] In 1977 in *Hamby v. McDaniel*, the court employed an extended quotation from *Roe* to support its position

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This material indicates that legislatures at the time of the adoption of the fourteenth amendment, the nineteenth century abortion laws, and the nineteenth century wrongful death statutes were not so naive as the California Supreme Court implied in its statement that it was "not so naive" as to believe the legislature could have entertained any idea of the fetus as a person when the wrongful death acts were passed in 1862 and 1872. Such legislatures could have included the unborn (from conception) in their understanding of the term "person." In fact this seems likely, since legislators were the specific targets of the national 'physicians' crusade." Interestingly, Justice Blackmun was aware of this crusade, for he cited material from it, *Roe*, 410 U.S. at 141, but failed to apply its implications.

[539] *Justus*, 19 Cal. 3d at 577, 565 P.2d at 130-31, 139 Cal. Rptr. at 105-06 (including the erroneous assertion that commentators generally opposed the cause of action for stillborn children).

[540] *Id.* at 575, 565 P.2d at 129, 139 Cal. Rptr. at 104.

[541] *Id.* at 581, 565 P.2d at 133, 139 Cal. Rptr. at 108.

[542] Witty v. American Gen. Capital Distribs., 727 S.W.2d 503, 505 (Tex. 1987).

[543] 390 So. 2d 357 (Fla. 1980).

[544] *Id.* at 359.

[545] 348 So. 2d 303 (Fla. 1977).

[546] *Id.* at 308.

[547] *Id.* at 306.

[548] Duncan v. Flynn, 358 So. 2d 178 (Fla. 1978).

[549] Hogan v. McDaniel, 204 Tenn. 235, 319 S.W.2d 221 (1958).

against the rising tide to the contrary.[550] The legislature has since amended the Tennessee code to allow a wrongful death action for a viable fetus.[551]

The Utah Supreme Court reserved the issue of a wrongful death action for a stillborn in *Nelson v. Peterson*.[552] Certain dicta indicate a sympathy for such an action.[553] However, in *Nelson*, the court said that it was not prejudicial for a jury to hear of the illegitimacy of the deceased unborn child because it would help in calculating the mother's damages for mental anguish, since "many women undergo abortions in such a situation . . . ."[554] Thus, *Roe's* influence was present although it should be noted that the first case holding there was no cause of action for an unborn child in Utah was decided before *Roe*.[555]

Nebraska,[556] New Jersey,[557] New York,[558] and Virginia[559] cases deciding wrongful death actions for unborn children made no mention of *Roe*. However, these cases were all decided before *Roe* or were based on prior cases that were. Montana only mentioned *Roe* in its discussion of California's rule, which it distinguished, and went on to say it was "beyond question" that the legislature should act to allow the cause of action.[560] Thus, in the cases denying recovery in wrongful death actions for the unborn, it is clear that *Roe* has had a negative effect on the growth of the law in certain states. Nevertheless, the trend continues to the present to reject the Supreme Court's holding in *Roe* that a fetus is not a person and allow a cause of action for the unborn. Ideally, "person" should mean the same in constitutional and statutory contexts. However, *Roe* is the exception to the rule, which was clear even in 1973, and any change ought to be in its holding, not in the tort law. *Roe* is increasingly out of step with this area of the law.

The Arizona Supreme Court stated the problem well in its 1985 rejection of the born-alive rule:

> The theoretical underpinnings of the *Dietrich* rule have been eroded,

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[550] 559 S.W.2d 774, 777-78 (Tenn. 1977).

[551] TENN. CODE ANN. § 20-5-106(b)(1980).

[552] 542 P.2d 1075 (Utah 1975).

[553] *See supra* note 523.

[554] *Nelson*, 542 P.2d at 1077.

[555] Webb v. Snow, 102 Utah 435, 132 P.2d 114 (1942).

[556] Smith v. Columbus Community Hosp., 222 Neb. 776, 387 N.W.2d 490 (1986); Egbert v. Wenzl, 199 Neb. 573, 573-74, 260 N.W.2d 480, 482 (1977)("We express no opinion with respect to the existence of the fetus as a person in either the philosophical or scientific sense.").

[557] Graf v. Taggert, 43 N.J. 303, 204 A.2d 140 (1964).

[558] Tebbutt v. Virostek, 65 N.Y.2d 931, 483 N.E.2d 1142 (1985)(citing its rule in Endresz v. Friedberg, 24 N.Y.2d 478, 301 N.Y.S.2d 65, 248 N.E.2d 901 (1969)).

[559] Lawrence v. Craven Tire Co., 210 Va. 138, 169 S.E.2d 440 (1969).

[560] Kuhnke v. Fisher, 210 Mont. 114, 120, 683 P.2d 916, 919 (1984).

> and both it and *Gorman v. Budlong*, 23 R.I. 169, 49 A. 704 (1901), the other early case which gave support to the rule of non-recovery, have been overruled by the very courts which decided them . . . . The majority finds no logic in the premise that if the viable infant dies immediately before birth it is not a 'person' but if it dies immediately after birth it is a 'person.'
>
> We take note, further, that the magic moment of 'birth' is no longer determined by nature. The advances of science have given the doctor, armed with drugs and scalpel, the power to determine just when 'birth' shall occur.[561]

Roe has also been cited as authority for allowing recovery in wrongful death actions for stillborn children because of the state's interest in potential life.[562] In *Eich v. Town of Gulf Shores*,[563] the Supreme Court of Alabama employed such an approach, as did the Oregon Supreme Court in *Libbee v. Permanente Clinic*.[564] The Oregon court noted that *Roe* held a fetus not to be a person under the fourteenth amendment, but decided the term meant something different under the Oregon Constitution.[565] Recently, the Ohio Supreme Court also cited *Roe* as supporting the protection of potential life and, therefore, recognizing a wrongful death action for the unborn was "entirely consistent with *Roe*."[566] The Supreme Court of Arizona also recognized a right of recovery for a stillborn child in 1985.[567] It argued that such an action "may further the policy of *Roe*" by protecting the woman's right to continue a pregnancy.[568] The Arizona court noted that, aside from protection of the right to continue one's pregnancy, *Roe* really was irrelevant in the wrongful death context, because voluntary termination of a pregnancy was quite distinguishable from termination "*against* the mother's will."[569]

Roe has also been influential in arguments for limiting recovery in wrongful death actions to the unborn who were viable. Georgia was the only pre-*Roe* state to allow recovery for a previable, stillborn fetus, allowing recovery for an unborn, "quick" child.[570] In 1976, Rhode Island abandoned any viability test in allowing recovery for stillborn infants, stating:

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[561] Summerfield v. Superior Ct., 144 Ariz. 467, 477, 698 P.2d 712, 722 (1985)(en banc). Also note the discussion of permissible judicial action in a developing area of the law created by statute. *Id.* at 472-73, 679, 689 P.2d at 717-18, 724.

[562] *Roe*, 410 U.S. at 162.

[563] 293 Ala. 95, 99, 300 So. 2d 354, 357 (1974).

[564] 268 Or. 258, 267, 518 P.2d 636, 640 (1974).

[565] *Id.*

[566] Werling v. Sandy, 17 Ohio St. 3d 45, 49, 476 N.E.2d 1053, 1056 (1985).

[567] Summerfield v. Superior Ct., 144 Ariz. 467, 698 P.2d 712 (1985)(en banc).

[568] *Id.* at 478, 698 P.2d at 723 (citing Kader, *supra* note 489).

[569] *Id.* (emphasis in original).

[570] Porter v. Lassiter, 91 Ga. App. 712, 87 S.E.2d 100 (1955).

> [V]iability is a concept bearing no relation to the attempts of the law to provide remedies for civil wrongs. If we profess allegiance to reason, it would be seditious to adopt so arbitrary and uncertain a concept as viability as a dividing line between those persons who shall enjoy the protection of our remedial laws and those who shall become, for most intents and purposes, nonentities. It seems that if live birth is to be characterized, as it so frequently has been, as an arbitrary line of demarcation, then viability, when enlisted to serve that same purpose is a veritable *non sequitur.*[571]

While the majority in the Rhode Island opinion never explicitly mentioned *Roe*, the harsh criticism of the viability test may betray a distaste for the Supreme Court's viability criterion. A concurring opinion does cite *Roe* as support for a viability dividing line.[572]

There is no logical reason why viability should be a criterion for recovery in a wrongful death action for a stillborn child. The viability requirement is no longer applied where the child is born alive. David Kader has stated: "[I]t is probably both desirable and inevitable that the viability requirement will likewise be abandoned to allow recovery by the beneficiary of a stillborn, notwithstanding any implications of *Roe v. Wade* to the contrary."[573] However, the implications of *Roe* show signs of stalling the progress predicted by Kader. In *Toth v. Goree*[574] a Michigan appeals court denied recovery for a three month old, nonviable fetus. The court said that any precedent "must be read in light of more recent developments in the case law. *Roe v. Wade* has had a considerable impact on the legal status of the fetus."[575] The court stated that there would be an inherent conflict if a person could be held liable under a wrongful death statute for the death of a child whom the mother could abort.[576] Of course, since the abortion right has developed to allow virtual abortion on demand throughout the pregnancy,[577] the Michigan court's reliance on the viability distinction may be misplaced. In 1975, it was still generally believed that states could effectively prohibit abortion after viability. Now it is apparent that a wrongful death action is inconsistent with the abortion right before and after viability.

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[571] Presley v. Newport Hosp., 117 R.I. 177, 188, 365 A.2d 748, 753-54 (1976).

[572] *Id.* at 192, 365 A.2d at 756 (Bevilacqua, C.J., concurring in part and dissenting in part).

[573] Kader, *supra* note 489, at 660.

[574] 65 Mich. App. 296, 237 N.W.2d 297 (1975).

[575] *Id.* at 303, 237 N.W.2d at 301 (citation omitted).

[576] *Id.*

[577] Thornburgh v. American College of Obstetrics & Gynecologists, 476 U.S. 747 (1986)(Burger, C.J., dissenting).

The New Hampshire Supreme Court has also noted the inherent contradiction with *Roe*:

> We remark in passing that it would be incongruous for a mother to have a federal constitutional right to deliberately destroy a nonviable fetus, *Roe v. Wade*, and at the same time for a third person to be subject to liability to the fetus for his unintended but merely negligent acts.[578]

In the most recent cases, *Roe's* viability emphasis is evident. The Pennsylvania Supreme Court, in *Amadio v. Levin*, said, "[t]he reasoning of the Court in *Roe* has been subject to widespread criticism and, at least as to the protectability of 'viable' unborn children, suffers from internal inconsistency."[579] Thus, the Pennsylvania court makes no mention of viability as a part of its rule. This probably indicates a rejection of a viability test.[580] The Ohio Supreme Court, in *Werling v. Sandy*,[581] specifically cited *Roe* as support for a viability standard, which it adopted.[582] The Arizona Supreme Court, in *Summerfield v. Superior Court*, claimed *Roe* was irrelevant but followed the majority in establishing a viability criterion.[583] The Supreme Court of North Dakota made no mention of *Roe* but followed the majority viability rule.[584]

Thus, it seems that the present trend is to require viability in a cause of action for wrongful death. *Roe* has certainly reinforced this trend. Interestingly, the viability line is seen as arbitrary by some courts who adopt it anyway because of the "weight of authority."[585] It makes little sense to abandon one arbitrary line for another, although moving to a viability criterion is a step in the right direction. *Roe's* illogical line drawing at viability will, unfortunately, have enduring effects in this area.

3. *Fetal rights in equity*

Equity is increasingly invoked to protect the rights of the unborn. It has taken on new dimensions with the recent development of fetal surgery[586] and increased concern about preventing injury to the unborn child through the negligence of the mother.[587] While a fetus may not have a right to be born, under *Roe*, the right to be born with a sound mind and body has increasingly been recognized.[588]

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[578] Wallace v. Wallace, 120 N.H. 675, 679, 421 A.2d 134, 137 (1980) (citation omitted).

[579] 509 Pa. 199, 225 n.5, 501 A.2d 1085, 1098 n.5 (1985) (Zappala, J., concurring).

[580] Most likely this is the case. *Id.* at 207, 501 A.2d at 1089 ("[T]he recovery afforded the estate of a stillborn is no different than the recovery afforded the estate of a child [born alive].").

[581] 17 Ohio St. 3d 45, 476 N.E.2d 1053 (1985).

[582] *Id.* at 49, 476 N.E.2d at 1056.

[583] Summerfield v. Superior Court, 144 Ariz. 467, 478, 698 P.2d 712, 723 (1985).

[584] Hopkins v. McBane, 359 N.W.2d 862 (N.D. 1984).

[585] *See, e.g.*, *Summerfield*, 144 Ariz. at 477, 698 P.2d at 722 ("We acknowledge . . . that this, too, is an artificial line . . . .").

A number of decisions have recently protected the unborn's right to life or health, even against maternal desire or convenience. These decisions are in marked contrast to the lack of protection for the fetus in abortion cases. Nowhere is the anomalous nature of the abortion right more visible.

Decisions which protect the unborn's right to life or health involve the right and obligation incidental to being a parent: the right and obligation to be the natural guardian of one's child.[589] This "private realm of family life" is protected from unwarranted state interference.[590] Family autonomy is not absolute, however,[591] and may be limited where "it appears that parental decisions will jeopardize the health or safety" of their children.[592] As a result, courts have acted to permit essential and necessary treatment of a child,[593] such as a blood transfusion[594] or vaccination,[595] despite parental refusal to consent to the treatment. Courts have ordered medical treatment over parental objections based on religious[596] and non-religious grounds.[597]

In some instances, pregnant women have refused medical treatment for themselves, which poses a serious risk to the life and health of their unborn children. While generally a person has a right to refuse medical care,[598] the state's interest in the welfare of children will justify compelling medical care when necessary to preserve the life of an unborn child.[599]

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[586] Lenow, *The Fetus as a Patient: Emerging Rights as a Person?*, 9 Am. J.L. & Med. 1 (1983).

[587] Note, *A Maternal Duty to Protect Fetal Health?*, 58 Ind. L.J. 531 (1983).

[588] Mathieu, *Respecting Liberty and Preventing Harm: Limits of State Intervention on Prenatal Choice*, 8 Harv. J.L. & Pub. Pol'y 19 (1985).

[589] Richards v. Forrest, 278 Mass. 547, 553, 180 N.E. 508, 511 (1932).

[590] Prince v. Massachusetts, 321 U.S. 158, 166 (1944).

[591] Custody of a Minor, 375 Mass. 733, 379 N.E.2d 1053 (1978).

[592] Wisconsin v. Yoder, 406 U.S. 205, 234 (1972).

[593] State v. Perricone, 37 N.J. 463, 181 A.2d 751 (1962).

[594] Brooklyn Hosp. v. Torres, 45 Misc. 2d 914, 258 N.Y.S.2d 621 (Sup. Ct. 1965).

[595] Mannis v. State, 240 Ark. 42, 398 S.W.2d 206, *cert. denied*, 384 U.S. 972 (1966).

[596] Jehovah's Witnesses of Washington v. King County Hosp., 278 F. Supp. 488 (D.D.C. 1967), *aff'd*, 390 U.S. 598 (1968). *See generally* Annotation, *Power of Court or Other Public Agency to Order Medical Treatment over Parental Religious Objections for Child Whose Life is not Immediately Endangered*, 52 A.L.R.3d 1118.

[597] Custody of a Minor, 375 Mass. 733, 379 N.E.2d 1053 (1978). *See generally* Annotation, *Power of Court or Other Public Agency to Order Medical Treatment for Child Over Parental Objections Not Based on Religious Grounds*, 97 A.L.R.3d 421.

[598] *See generally* Annotation, *Patient's Right to Refuse Treatment Allegedly Necessary to Sustain Life*, 93 A.L.R. 3d 67.

In two pre-*Roe* cases, *Hoener v. Bertinato*[600] and *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*,[601] a New Jersey juvenile court and the state's supreme court justified, under their parens patriae power, authorizing a hospital to give lifesaving blood transfusions to save the life of a child, even though the parents objected on religious grounds. In *Hoener*, the court authorized a blood transfusion to the child immediately after birth to correct an Rh factor problem that caused the death of the woman's previous child. It remained for the *Anderson* case to extend this principle to the child yet unborn.

In *Anderson*, the New Jersey Supreme Court decided whether a pregnant Jehovah's Witness could be compelled, against her religious beliefs, to take a blood transfusion. The court unanimously held that the thirty-two week old child was entitled to the law's protection and ordered the transfusions, stating:

> In *State v. Perricone* we held that the State's concern for the welfare of an infant justified blood transfusions notwithstanding the objection of its parents who were also Jehovah's Witnesses, and in *Smith v. Brennan* we held that a child could sue for injuries negligently inflicted upon it prior to birth. We are satisfied that the unborn child is entitled to the law's protection and that an appropriate order should be made to insure blood transfusions to the mother in the event that they are necessary in the opinion of the physician in charge at the time.[602]

This was the first case in which a court ordered procedures which invaded a mother's bodily integrity to benefit the unborn fetus.[603] The court determined that the child's right to live outweighed the woman's constitutionally protected right to practice her religion, as well as her right to refuse medical treatment and her right to bodily integrity. The court noted that the fact that the child and woman "are so intertwined and inseparable"[604] made the decision easier to make than if it were just an adult involved, underscoring the paramount status of the interest in protecting the child in the decision. Here the child was viable. *Roe* would have at least recognized the state's interest in the child's potentiality of life.

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[599] *In re* Melideo, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (1976); *In re* Yetter, 62 Pa. D. & C.2d 619 (1973); Hoener v. Bertinato, 67 N.J. Super. 517, 171 A.2d 140 (Juv. Ct. 1961).

[600] 67 N.J. Super. 517, 171 A.2d 140 (Juv. Ct. 1961).

[601] 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

[602] *Id.* at 423, 201 A.2d at 539 (citations omitted).

[603] Lenow, *supra* note 586, at 21.

[604] *Anderson*, 42 N.J. at 423, 201 A.2d at 538.

In *Jefferson v. Griffin Spalding County Hospital Authority*,[605] the Georgia Supreme Court approved more intrusive measures. A pregnant women suffered from complete placenta previa (a condition where the placenta covers the opening of the birth canal). A ninety-nine percent chance of fetal fatality was predicted if a natural birth was attempted. The physicians also predicted a fifty percent chance that the mother would die with natural birth. Both had excellent chances of surviving a Caesarian section. The court upheld an order requiring the woman to submit to a sonogram, blood transfusions, and a Caesarian section should they be found necessary to sustain the life of the thirty-nine week old child, even though Mr. and Mrs. Jefferson opposed the operation on religious grounds. The order provided for custody of the unborn child to be granted to the state for the purpose of requiring surgery. The court stated that *Roe* indicated the state had a compelling interest in the life of the fetus after viability. Justice Hill concurring in the per curiam opinion, said:

> [W]e weighed the right of the mother to practice her religion and to refuse surgery on herself, against her unborn child's right to live. We found in favor of her child's right to live.[606]

As it turned out, a subsequent ultrasound revealed that the placenta had shifted—a very rare occurrence—and the Caesarian was unnecessary.[607]

A recent survey indicated that courts in eleven states have ordered Caesarian deliveries to protect fetuses.[608] Only one of these cases was reported; most even elude the newspapers.[609] After surveying the cases, one author wrote, "In the cases of which I am aware, every judge but one who has ruled on an application for nonconsensual Cesarean delivery has granted the request.[610]

In November, 1987, the Court of Appeals for the District of Columbia continued this trend. In the case of *In re A.C.*, the court held that the interests of an unborn child and the state outweighed the right of a pregnant woman against bodily intrusion.[611] The mother was terminally ill, in extremis, lucid only at intervals, and with only hours to live; the fetus was twenty-six weeks old and experiencing oxygen deprivation.[612] The court-ordered Caesarean delivery was performed—mother and child died soon after.[613]

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[605] 247 Ga. 86, 274 S.E.2d 457 (1981).

[606] *Id.* at 90, 274 S.E.2d at 460.

[607] Lenow, *supra* note 586, at 21 n.123.

[608] Kolder, Gallagher & Parsons, *Court Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1194 (1987).

[609] Rhoden, *Cesareans and Samaritans*, 15 LAW, MED. & HEALTH CARE 118 (1987).

[610] *Id.* at 118 (footnote omitted).

[611] 533 A.2d 611 (D.C. 1987), *vacated and reh'g en banc granted*, 539 A.2d 203 (D.C. 1988).

In the 1983 case of *Taft v. Taft*,[614] the issue of court-ordered surgery to protect the fetus was raised before the Massachusetts Supreme Judicial Court. The woman was four months pregnant. Her husband sought a court order to force her to submit to a "purse string" operation, so her cervix would hold the pregnancy.[615] The woman wanted the child, but she refused to undergo the surgery for religious reasons. The lower court appointed a guardian ad litem for the unborn child and granted the husband authority to consent to the operation. On appeal, the Massachusetts Supreme Judicial Court reversed. It stated that "[no] case has been cited to us, nor have we found one, in which a court ordered a pregnant woman to submit to a surgical procedure in order to assist in carrying a child not then viable to term."[616] The court reserved judgment on whether the state's interest in the unborn was compelling enough to allow such overriding of the mother's privacy and right to "free exercise" of religious beliefs.[617]

The *Taft* court, however, did not close the door to ordering surgical procedures to protect the unborn. The court specifically noted the sparse record regarding necessity "as a life saving procedure" or likelihood of success.[618] The court added that the state's interest "might be sufficiently compelling" if the state's interest were "established."[619]

Significantly, the *Taft* decision involved a previable fetus. Interestingly, the court made no mention of *Roe*. However, the inference was clear that the viability point, which was significant in the original abortion cases, played no role in the consideration of imposed treatment on behalf of the unborn. Obviously, the viability criteria is arbitrary, meaningless, and contrary to reason. It was rightly not considered.

The prevention of disabilities is a strong state interest, with which many are sympathetic. Many of these disabilities are preventable by proper prenatal care.[620] This is a growing area in the establishment of fetal rights. In a 1980 case, *In Re Baby X*,[621] a newborn had demonstrated symptoms of narcotics withdrawal within a day of birth. The court held that evidence of the mother's prenatal drug use constituted abuse and neglect. The court took temporary custody of the child. However, since the same court had previously held a fetus not to be a person under the child custody statute, the state's equitable powers to protect the unborn are limited. In an unreported case,[622] a court enjoined a pregnant woman from using drugs and ordered a weekly urinalysis to protect the fetus.

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[612] *Id.*

[613] *Id.*

[614] 388 Mass. 331, 446 N.E.2d 395 (1983).

[615] *Id.* at 332, 446 N.E.2d at 396.

[616] *Id.* at 334 n.4, 446 N.E.2d at 397 n.4.

[617] *Id.* at 334, 446 N.E.2d at 397.

[618] *Id.* at 335, 446 N.E.2d at 397.

[619] *Id.* at 334-35, 446 N.E.2d at 397.

[620] Parness, *The Duty to Prevent Handicaps: Laws Promoting the Prevention of Handicaps to Newborns*, 5 W. New Eng. L. Rev. 431 (1983).

[621] 97 Mich. App. 111, 293 N.W.2d 736 (1980).

It is unclear how far the states will go in ordering fetal surgery or medical procedures to protect the life of the unborn child. The court in *Jefferson* used a viability standard, as per *Roe*, but what happens when medical advances push back the stage of viability? And what effect will the trends and forces which have engineered the expansion of prenatal tort law have upon this area of the law? Will previable unborn children become the subject of court ordered fetal surgery against the wishes of a mother?

The growth of fetal treatment capabilities and litigation will force further consideration of the rights of the unborn. Surely, some criteria must be established. The early returns indicate that fetal rights are being recognized in the balance with the mother's rights. This is appropriate. Hopefully, the influence of *Roe* will not halt this growing trend. While women's rights must be placed in the balance, it is certainly equitable that unborn fetuses be allowed to develop without preventable handicaps and injuries.[623]

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[622] Boston Globe, April 27, 1983, at 8, col. 1.

[623] *See id.*; Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?*, 23 DUQ. L. REV. 1 (1984); Note, *Informed Consent: An Unborn's Right*, 48 ALB. L. REV. 1102 (1984). *Contra* Johnson, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599 (1986). As indicated in the text above, a pregnant woman's duty to her unborn child includes the duty to provide life-saving medical care. The failure to provide medical care for a child can also carry criminal penalties. *See generally* Annotation, *Failure to Provide Medical Attention for Child as Criminal Neglect*, 12 A.L.R.2d 1047. Thus, a father could be guilty of a misdemeanor for failure to furnish medical attention to an unborn child, People v. Sianes, 134 Cal. App. 355, 25 P.2d 487 (1933), as long as it is shown that the child, as distinguished from the mother, is adversely and substantially affected by the lack of medical attention. People v. Yates, 114 Cal. App. Supp. 782, 298 P. 961 (1931).

In a number of different contexts, courts have ruled that the unborn is a member of the family and a dependent. A California court has held that an unborn child had a right to support from his or her father and ordered the father to fulfill his duty. Kyne v. Kyne, 38 Cal. App. 2d 122, 100 P.2d 806 (1940). *Accord* People v. Yates, 114 Cal. App. Supp. 782, 298 P. 961 (1931); Metzger v. People, 98 Colo. 133, 53 P.2d 1189 (1936). The primary duty of a parent to a child is to provide the child with support and protection. *See generally*, Annotation, *Propriety of Decree in Proceeding Between Divorced Parents to Determine Mother's Duty to Pay Support for Children In Custody of Father*, 98 A.L.R.3d 1146. In this regard, the duty to support may not be contracted away, even when the child is unborn. Wilson v. Wilson, 251 Ky. 522, 65 S.W.2d 694 (1933). The obligation of a parent to support his or her children may be enforced by an action at any time during the child's minority, *see, e.g.*, Strecker v. Wilkinson, 220 Kan. 292, 552 P.2d 979 (1976), and may be brought on behalf of a child not yet born. *See, e.g.*, McCoy v. People *ex rel.*

The significant point, however, is the strong protection given the

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[Minor] Child, 165 Colo. 407, 439 P.2d 347 (1968) (en banc). In addition, an order of support may be modified for the purpose of making allowance for the support of a child born since the filing of the original proceeding, even when the decree provided for the support of the child while unborn. *See, e.g.*, Schneider v. Schneider, 188 Neb. 80, 195 N.W.2d 227 (1972).

Most states have made the nonsupport of a child a criminal offense. *See generally* 67A C.J.S. *Parent & Child* § 165. These statutes include an unborn child, who has been held to be a minor child within the meaning of a statute declaring willful nonsupport of a minor child to be an offense. People v. Yates, 114 Cal. App. Supp. 782, 298 P. 961 (1931). In this regard, the support is to be furnished through the mother. Where nothing at all in the way of food, clothing or shelter is furnished by the father to the expectant mother, a breach of duty to provide for the unborn child is shown. *Id.*

The Louisiana Supreme Court allowed an unborn child to bring an action to prove paternity, which would entitle the child to support and heirship. Malek v. Yekani-Fard, 422 So. 2d 1151 (La. 1982). Such decisions rest on the long recognized rights of the unborn in property and family law. Other related rights and obligations arise from the parent-child relationship as applied to unborn children. One substantial right is the presumption of legitimacy of birth. This presumption is "one of the strongest and most persuasive known to the law," *In re* Findlay, 253 N.Y. 1, 170 N.E. 471 (1930), and extends to a child conceived in wedlock but born after the termination of the marriage. *See generally* Annotation, *Presumption of Legitimacy of Child Born after Annulment, Divorce, or Separation*, 46 A.L.R.3D 158. As a result, a child conceived by artificial insemination of the wife during a valid marriage has been held to be a legitimate child, entitled to all the rights and privileges of a naturally conceived child of the same marriage. *In re* Adoption of Anonymous, 74 Misc. 2d 99, 345 N.Y.S.2d 430 (1973). Further, a surrogate mother, impregnated by artificial insemination with semen of a man not her husband, has been held unable to terminate her parental rights in the child and have custody of the child transferred to the biological father. *In re* Baby Girl, FAM. L. REP. 2348 (1983).

In Alabama Farm Bureau Mutual Casualty Insurance v. Pigott, 393 So. 2d 1379 (Ala. 1981), the Alabama Supreme Court held that the unborn grandson of the insured was a member of the family of the insured for the purpose of being covered by the uninsured motorist clause in the named insured's policy. *See also* Peterson v. Nationwide Mut. Ins., 175 Ohio St. 551, 197 N.E.2d 194 (1964). In Adams v. Weinberger, 521 F.2d 656 (2d Cir. 1975), the Second Circuit Court of Appeals found that a posthumously born illegitimate child was entitled to his late father's social security survivor benefits. The test to qualify for the benefits was whether the support by the father for the unborn child was commensurate with the needs of the unborn child at the time of the father's death. *See also* Wagner v. Finch, 413 F.2d 267 (5th Cir. 1969); Moreno v. Richardson, 484 F.2d 899 (9th Cir. 1973). Also, in S.L.W. v. Alaska Workmen's Compensation Board, 490 P.2d 42 (Alaska 1971), a posthumously born child had the right of recovery for workmen's compensation death benefits, even though the father was unaware of the pregnancy at the time of his death. *See also* Fontenot v. Annelida Acres, Inc., 302 So. 2d 690 (La. Ct. App. 1974).

In addition, for purposes of inheritance and trust laws, the unborn has long been recognized as a child with full rights as any born child. *See* 1 W. BLACKSTONE, COMMENTARIES *130 ("An infant . . . in the mother's womb . . . is capable of having a legacy, or a surrender of a copyhold estate, made to it. It may have a guardian assigned to it; and it is enabled to have an estate limited to its use, and to take afterwards by such limitation, as if it were then actually born."). As a result, an unborn child can, among other things, inherit and own an estate, Hall v. Hancock, 32 Mass. (15 Pick.) 255 (1834); Aubuchon v. Bender, 44 Mo. 560 (1869), be a tenant-in-common with his brothers and sisters, Deal v. Sexton, 144 N.C. 157, 56 S.E. 691 (1907), or with his own mother, Biggs v. McCarty, 86 Ind. 352 (1882), be an actual income recipient prior to birth, Industrial Trust Co. v. Wilson, 61 R.I. 169, 200 A. 467 (1938), and take property by deed from an inheritance. Mackie v. Mackie, 230 N.C. 152, 52 S.E.2d 352 (1949). By 1941, a New York court, *In re* Holthausen, 175 Misc. 1022, 26 N.Y.S.2d 140 (1941), summed up the law concerning property rights of the unborn child as follows:

unborn. This is out of step with the inadequate protection of fetal rights in abortion law.

4. *Fetal rights in criminal law*

"The criminal law historically has afforded the unborn child a substantial amount of protection," noted David Louisell in 1969.[624] The effect of *Roe* has been to strip away much of this protection. While the criminal law gave some of the unborn legal rights as "persons," *Roe's* declaration that they were not persons, for purposes of the fourteenth amendment, has spilled over into areas beyond abortion. Theoretically, the Court's holding for fourteenth amendment purposes has no bearing on personhood for homicide laws, but some state courts seem unable to grasp the distinction. Perhaps what is at work is the intuitive notion underlying stare decisis, that the law should be consistent. In other words, persons who have been "persons" under the criminal law should remain so or have no rights at all. Apparently, it is felt that the Court has taken such a radical step in stripping the unborn of their personhood in *Roe* that it cannot have meant to leave personhood in place for other purposes. Also, it is felt by some abortion advocates that the growth and maintenance of fetal rights in such an analogous area as homicide undercuts *Roe* and so must be inhibited.[625]

Such reasoning has brought about the astonishing result in the California cases regarding homicide of an unborn child. A murder indictment had been brought against a man for killing an unborn child. He had shoved his knee into his pregnant ex-wife's abdomen, saying, "I'm going to stomp it out of you." In 1970, the California Supreme Court reversed the murder indictment in *Keeler v. Superior Court*,[626] applying the born-alive rule.[627] Within the same year, the legislature

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> It has been the uniform and unvarying decision of all common-law courts in respect of estate matters for at least the past two hundred years that a child *en ventre sa mere* is 'born' and 'alive' for all purposes for his benefit.

Id. at 1024, 26 N.Y.S.2d at 143.

With regard to the disposition of an inheritance, a guardian ad litem may be appointed where the alleged father of the unborn had died and his estate was pending. *In re* Thomas, 118 Misc. 2d 456, 460 N.Y.S.2d 716 (1983). Similarly, with regard to the law of trusts, an unborn beneficiary cannot be bound by the consent of living beneficiaries, *In re* Estate of Allen, 35 Haw. 501 (1940), and a guardian ad litem can be appointed by the court to consent to a modification or revocation of the trust. Hatch v. Riggs Nat'l Bank, 361 F.2d 559 (D.C. Cir. 1966). Thus, with few limitations, the unborn child is considered the child of his parents with the full rights of a born child and to which the parents owe substantial duties.

[624] Louisell, *Abortion, the Practice of Medicine and the Due Process of Law*, 16 UCLA L. REV. 233, 238 (1969).

[625] *See, e.g.*, Johnson, *supra* note 623.

[626] 2 Cal. 3d 619, 470 P.2d 617, 87 Cal. Rptr. 481 (1970) (en banc).

[627] The born-alive rule is an ancient relic from the fourteenth century, when proof

promptly redefined homicide to include the killing of a fetus.[628] In the 1976 case of *People v. Smith*,[629] the state appealed the dismissal of a homicide charge for a man who allegedly murdered a nonviable fetus. The appellate court held that *Roe* had removed the protection of a nonviable fetus:

> The underlying rationale of [*Roe*], therefore, is that until viability is reached, human life in the legal sense has not come into existence. Implicit in [*Roe*] is the conclusion that as a matter of constitutional law the destruction of a non-viable fetus is not a taking of human life. It follows that such destruction cannot constitute murder or other form of homicide, whether committed by a mother, a father (as here), or a third person.[630]

The *Smith* court failed to distinguish between the fourteenth amendment context and the homicide context. Amazing as the result in *Smith* seems, the underlying notion that the legal treatment of the unborn ought to be consistent is sound. However, the only satisfactory way to make the law logically consistent is to give the unborn protection in all contexts. If the courts refuse such complete protection, then they ought to distinguish recognition of personhood for different contexts and at least provide protection to the unborn when abortion is not at issue. Under the clear influence of *Roe*, California chose the worst possible result—no protection at all.

A similar result was reached in Louisiana. In *State v. Gyles*,[631] the Louisiana Supreme Court held that the unborn were not included as "human beings" for the purposes of the homicide statute. The court noted that the legislature could amend the criminal code, in keeping with *Roe's* restrictions.[632] An amendment was adopted the next year, making the term "person" denote "a human being from the moment of fertilization and implantation."[633] Yet, the same court in *State v. Brown*,[634] where the defendant had beaten a woman and her unborn child to death, held the amendment did not expand homicide to include feticide. The court cited a need for greater clarity and less confusion than the word "person" reflects and a need to remain "within the lim-

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problems resulted from medical limitations in determining causation. Commonwealth v. Cass, 392 Mass. 799, 805, 467 N.E.2d 1324, 1328 (1984).

[628] CAL. PENAL CODE § 187 (West 1988).

[629] 59 Cal. App. 3d 751, 129 Cal. Rptr. 498 (1976).

[630] *Id.* at 755, 129 Cal. Rptr. at 502.

[631] 313 So. 2d 799 (La. 1975).

[632] *Id.* at 802.

[633] LA. REV. STAT. ANN. § 14:2(7) (West 1986).

[634] 378 So. 2d 916 (La. 1979).

its fixed in *Roe v. Wade*."[635]

These decisions were clearly misguided under a correct analysis of *Roe*. No privacy interests were involved on the part of the woman. The legislative intent was clear, and the state had strong interests in preventing assaults on unborn children, preventing their physical impairment and death, and protecting a woman's fundamental right of choosing to carry her child to term.[636]

The result of such decisions, in both California and Louisiana, has been noted by one commentator:

> The irony of the *Keeler* decision is that, had the defendant's assault on the unborn child been somewhat less severe or even less accurate so that the child was born alive before she died from the injuries, the crime would clearly have been murder. [A footnote indicated that under the born-alive rule the child need only have lived a short time after birth to have established homicide.] It is therefore to the defendant's advantage to be sure that he has killed, rather than merely injured, the child in *utero*. One would have to search long and hard to find a better example of inverse justice at work.[637]

The *Keeler* case has had widespread influence. It is regularly quoted in cases following its result. For example, Minnesota, in 1985, denied a cause of action on behalf of a viable eight and a half month fetus under its vehicular homicide statute.[638] It cited *Keeler* twice.[639] Also in 1985, a New York court followed *Keeler's* lead, prominently citing "*Keller* [sic]."[640] In 1984, West Virginia held that the killing of a thirty-seven week fetus did not constitute homicide.[641] *Keeler* was given special mention.[642] Also in 1984, an appellate court in Florida cited *Keeler* and *Roe* in holding that the killing of a fetus did not constitute DWI manslaughter nor vehicular homicide.[643] This case was remarkable because, at the time of the automobile accident, the mother was in labor with a full-term viable fetus.[644] Further, the legislature had expressed its will in the criminal area by including willful feticide within the crime of manslaughter.[645] Arguing strict construction, the court refused to abandon the born-alive rule for the nonwillful crimes charged.[646] In 1983, the Supreme Court of Kentucky decided that a fetus was not protected by the murder statute in the case of *Hollis v. Commonwealth*.[647] Hollis reportedly took his estranged wife from her parents' home to their barn.[648] She was twenty-eight to thirty weeks pregnant.[649] He "told her he did not want a baby, and then forced his hand up her vagina intending to destroy the child and deliver the fetus."[650] The court discussed *Roe* extensively, concluding, "It is fundamental that this Court has no authority to disagree with a decision of the United States Supreme Court interpreting the Federal Constitution."[651]

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[635] *Id.* at 918.

[636] Maher v. Roe, 432 U.S. 464, 472 n.7 (1977).

[637] Note, *supra* note 478, at 367-68.

[638] State v. Soto, 378 N.W.2d 625 (Minn. 1985).

[639] *Id.* at 628 n.7, 630.

[640] People v. Joseph, 130 Misc. 2d 377, 496 N.Y.S.2d 328 (Orange City Ct. 1985).

[641] State v. Wilson, 332 S.E.2d 807 (W. Va. 1984).

[642] *Id.* at 808 n.3.

[643] State v. McCall, 458 So. 2d 875 (Fla. Dist. Ct. App. 1984).

[644] *Id.* at 876.

[645] *Id.* at 877.

Another widely cited case which followed *Keeler* was the 1980 Michigan case of *People v. Guthrie*.[652] In 1983, Justice Ryan of the Michigan Supreme Court, dissenting in the vacating of leave to appeal the case, noted that the full-term infant in that case was "ready for birth," and was killed when the mother's vehicle was struck head-on by a pickup truck which had "crossed four lanes, including the centerline."[653] It was the "day before she was scheduled to enter the hospital for a Caesarean Section delivery."[654] The Michigan courts applied the born-alive rule despite earlier state court recognition of the unborn as within the state homicide statute. Instead of resorting to such precedent, the Michigan court relied on the outmoded common law born-alive rule.[655] Had the infant been scheduled for delivery a day earlier, and been riding home in an infant seat, it would have qualified for protection under the negligent homicide act. Such results, dependent on the vicissitudes of scheduling, are illogical. As dissenting Justice Ryan noted:

> The 'rule' is generally understood to derive from the impossibility, 300 years ago, of determining whether and when a fetus was living and when and how it died, and the consequent necessity to preclude the fundamental inquiry whether a fetal death was a human death.
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> To hold as a matter of law in the waning years of the twentieth century that the question of the personhood or humanity of a viable

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[646] *Id.*
[647] 652 S.W.2d 61 (Ky. 1983).
[648] *Id.*
[649] *Id.*
[650] *Id.*
[651] *Id.* at 63.
[652] 97 Mich. App. 226, 293 N.W.2d 775 (1980) , *appeal dismissed*, 417 Mich. 1006, 334 N.W.2d 616 (1983).
[653] People v. Guthrie, 417 Mich. 1006, 334 N.W.2d 616 (1983) (Ryan, J., dissenting).
[654] *Id.*
[655] *Id.* at 1008-9, 334 N.W.2d at 618-19.

> unborn child in the ninth month of gestation is governed by a common law rule of proof invented by the venerable but fallible Sir Edward Coke in the seventeenth century, to accommodate the medical and scientific impossibility of then proving the viability of a fetus, is disingenuous reasoning in the extreme.[656]

Medical testimony at the preliminary examination indicated that proof of life, viability, and cause of death were no longer the problems envisioned in the antiquated born-alive doctrine.[657]

In 1982, a New Mexico appellate court also followed *Keeler* in *State v. Willis*[658] by rejecting a vehicular homicide indictment for the killing of a fetus. In 1981, New Jersey reached the same conclusion in *State ex rel. A.W.S.*,[659] citing *Keeler* and *Guthrie*.

Another widely quoted case is *People v. Greer*, decided by the Illinois Supreme Court in 1980.[660] The court followed *Keeler* by holding it was not murder to kill an eight and a half month fetus by beating.[661]

In 1986, Connecticut decided that an unborn, viable fetus was not a "human being" within the meaning of the state murder statute, in *State v. Anonymous*.[662] *Keeler* was heavily relied upon in that decision.[663]

Thus, it is evident that *Roe* and *Keeler* have been very influential.[664] As discussed above, the reliance on *Roe* in this context is totally unfounded. *Keeler* presents a more persuasive precedent. It was decided, as were many of the subsequent cases, on the basis of stare decisis, strict construction, and the due process concern of giving adequate notice to defendants.

As this article argues, stare decisis serves important functions. However, when the rationale for a precedent is outmoded, such as it is for the born alive rule, common sense dictates that the precedent no longer be followed. This principle has been widely applied in the analogous areas of wrongful death statutes and tort law. It is widely acknowledged by the courts that medical science has progressed and the law should be "presumed to keep pace with the sciences."[665] There really is no serious issue here, since even courts which exclude the unborn from homicide statutes acknowledge the outdated rationale of the rule. For example, in *Guthrie*,[666] the court wrote:

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[656] *Id.* at 1007, 334 N.W.2d at 617 (citation omitted).

[657] *Id.*

[658] 98 N.M. 771, 652 P.2d 1222 (1982).

[659] 182 N.J. Super. 278, 440 A.2d 1144 (App. Div. 1981).

[660] 79 Ill. 2d 103, 402 N.E.2d 203 (1980).

[661] *Id.*

[662] 40 Conn. Supp. 498, 516 A.2d 156 (Conn. Super. Ct. 1986).

[663] *Id.* at 500, 516 A.2d at 158-159. In 1987, in the case of *Meadows v. State*, 291 Ark. 105, 722 S.W.2d 584 (1987), the Supreme Court of Arkansas held that reckless killing of a viable fetus was not within the state manslaughter statute. Arkansas was unique in having an early feticide statute which had been expressly repealed. *Id.* at 587. From this, the court decided that legislative intent did not include the unborn within the manslaughter statute. *Id.*

[664] Another case preceding *Roe* excluded fetuses from vehicular homicide statutes. State v. Dickinson, 28 Ohio St. 2d 65, 275 N.E.2d 599 (1971).

> This panel agrees that the "born alive" rule is outmoded, archaic and no longer serves a useful purpose. Modern medical practice has advanced to the point that, unlike the situation when the rule was first developed, the vast majority of viable fetuses will, in the absence of some unexpected event, be born alive and healthy. Further, medical technology can now accurately determine the stages of fetal development and viability. This being so, birth itself in terms of emergence from the mother's body should no longer be determinative. We further acknowledge that for purposes of actions in tort for wrongful death, recovery may be had even if a viable fetus was yet unborn.[667]

Thus, an application of stare decisis here is a brittle, mechanical application of the doctrine. Even worse, it works injustice. It is instructive to compare the rigid way that this precedent has been applied with the inflexible/flexible approach used in abortion jurisprudence. In the latter, the only inflexible point is that women may have abortions. Everything else is limply pliable. Here, while denying the validity of the rationale, the courts continue to apply the rule. Clearly, the unborn are deserving of more protection.[668] Even *Roe* indicated the compelling state interest in fetal life where women's privacy interests were not opposed.[669] Apparently, the explanation for this negative trend of feticide law lies somewhere beyond the realm of mere stare decisis. It lies largely in the negative influence of *Roe*.

The courts denying homicide actions for the unborn also cite the due process right of defendants to have notice of what constitutes unlawful conduct.[670] It is difficult to believe that a defendant who intentionally sought to "stomp" a baby out of the womb,[671] or tear it out vaginally,[672] or stab its mother in the abdomen when she was full-term[673] would not believe he was acting criminally. The cases would give him notice that, if the child were born and lived only briefly, he would be liable for homicide. It seems incredible then to say that he had no notice. How was he to be certain the child would not survive to draw a breath? Or are we seeking to reward the lethally efficient, who make no mistakes? It may be somewhat of a legal fiction to imagine that a man in the act of stabbing his wife in her pregnant womb is counting on the rule that he is absolved of criminal liability if he succeeds in killing the child. At least, he should be on notice of the doctrine of transferred intent;[674] if he attacks the mother with malice and kills the unborn child unintentionally, he should be liable for having intended the act.[675]

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[665] Bonbrest v. Kotz, 65 F. Supp. 138, 143 (1946).

[666] 97 Mich. App. 226, 293 N.W.2d 775 (1980), *appeal dismissed*, 417 Mich. 1006, 334 N.W.2d 616 (1983).

[667] *Id.* at 232, 293 N.W.2d at 778. This passage was quoted approvingly in New Jersey's rejection of homicide protection for the fetus as well, in 1981. State *ex rel.* A.W.S., 182 N.J. Super. 278, 281, 440 A.2d 1144, 1146 (App. Div. 1981).

[668] Parness, *supra* note 462.

[669] *Roe*, 410 U.S. at 162.

[670] *See, e.g.*, State v. Horne, 282 S.C. 444, 445, 319 S.E.2d 703, 704 (1984).

[671] *Keeler*, 2 Cal. 3d 619, 470 P.2d 617, 87 Cal. Rptr. 481.

[672] Hollis v. Commonwealth, 652 S.W.2d 61 (Ky. 1983).

Furthermore, with the rapid growth of fetal rights in tort law, especially wrongful death, it should come as no great surprise to an intentional killer of an unborn child if some state decides he has murdered a person. This is especially true in a state like Minnesota which has been active and well-known for advancing fetal rights in its much-publicized case, *Verkennes v. Corniea,*[676] where it recognized the unborn as persons.[677]

Finally, there is a simple solution to the concern with notice. While it works tragic injustice in an initial case, the employment of a holding with prospective effect only solves the dilemma easily. This solution was found satisfactory in *Commonwealth v. Cass*[678] and in *State v. Horne.*[679]

The remaining argument of the majority[680] is the doctrine of construing criminal statutes strictly. The purposes behind the rule are fairness[681] and avoidance of judicial usurpation of the legislative function.[682] In *Cass*, Massachusetts decided that fairness to the defendant (notice) was really the central issue of narrow construction and resolved it, as discussed above, by prospective application of its rule.[683] Of course, the principle of fairness is one that should be considered both as it relates to the alleged criminal and to the victim. Clearly, the victim's rights have received short shrift in most courts.

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[673] State v. Horne, 282 S.C. 444, 319 S.E.2d 703 (1984).

[674] *Id.* at 446-47, 319 S.E.2d at 704.

[675] *Id.*

[676] 229 Minn. 365, 38 N.W.2d 838 (1949).

[677] Unfortunately, Minnesota rejected this argument in State v. Soto, 378 N.W.2d 625 (Minn. 1985).

[678] 392 Mass. 799, 467 N.E.2d 1324 (1984).

[679] 282 S.C. 444, 319 S.E.2d 703 (1984).

[680] The born-alive rule, in criminal cases, has been followed by 24 of the 26 jurisdictions which have considered it. *Soto*, 378 N.W.2d at 628 (including *Soto* in the sum).

[681] *Cass*, 392 Mass. at 804, 467 N.E.2d at 1327.

[682] *Soto*, 378 N.W. at 627-28.

[683] *Cass*, 392 Mass. at 807-08, 467 N.E.2d at 1329

The other foundation of the narrow construction rule involves the nature of the judicial function. The *Soto* court argued: "The rule of strict construction of criminal statutes is essential to guard against the creation of criminal offenses outside the contemplation of the legislature, under the guise of 'judicial construction.' "[684]

Two courts have stood against the trend denying fetal protection under homicide statutes and have discussed the rules of strict construction of criminal statutes. These will be examined to determine if their logic is compelling. Do they properly address the issue of common law development of criminal statutes? Of course, the nature of the statutes will affect the outcome in individual cases. However, general themes are transferable among the codes and cases.

In the 1984 case of *State v. Horne*,[685] South Carolina announced that a viable fetus would henceforth be a person for purposes of the homicide law. In its rationale, it first set forth a stare decisis argument based on consistency: "It would be grossly inconsistent for us to construe a viable fetus as a 'person' for the purposes of imposing civil liability while refusing to give it a similar classification in the criminal context."[686] Then the court noted prior changes made in the criminal law by the South Carolina Supreme Court itself:

> This Court has the right and the duty to develop the common law of South Carolina to better serve an ever-changing society as a whole. In this regard, the criminal law has been the subject of change. The fact this particular issue has not been raised or ruled on before does not mean we are prevented from declaring the common law as it should be. Therefore, we hold an action for homicide may be maintained in the future when the state can prove beyond a reasonable doubt the fetus involved was viable . . . .[687]

The more famous case of *Commonwealth v. Cass*[688] was also decided in 1984, by the Supreme Judicial Court of Massachusetts. Massachusetts had the advantage of a prominent case, extending wrongful death rights to the unborn,[689] published a year before the vehicular homicide statute was passed. Thus, the court could reasonably argue that the legislature was presumed to be aware of state court developments, and so must have intended the definition of a "person" in *Mone* to apply to the new statute.[690]

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[684] State v. Soto, 378 N.W.2d 625, 628 (Minn. 1985).

[685] 282 S.C. 444, 319 S.E.2d 703 (1984).

[686] *Id.* at 445, 319 S.E.2d at 704.

[687] *Id.* (citations omitted).

[688] 392 Mass. 799, 467 N.E.2d 1324 (1984).

[689] Mone v. Greyhound Lines, 368 Mass. 354, 331 N.E.2d 916 (1975).

Despite a similar sequence of case and statute, Minnesota recently rejected the *Cass* approach.[691] The court noted that the two courts which had rejected the born-alive rule were "common law" jurisdictions, while Minnesota was a "code state," i.e., the Minnesota legislature specifically abolished common law crimes.[692] The Minnesota court noted its authority to construe the law, but said a change of such magnitude in the criminal law was "within the province of the legislature."[693] This is the common argument of the majority, which follows *Keeler*.[694]

In analyzing this argument, it should be acknowledged at the outset that the general rule is correct. More judicial restraint is to be encouraged. It is troubling, however, when courts, including the United States Supreme Court, can "legislate" freely to strip the unborn of personhood, but suddenly cannot do so to grant it. In addition, the legislatures need to act clearly and unambiguously to protect the state interest in the unborn. However, where they have attempted to do so, as in California and Louisiana, the courts have offered a hostile reception.[695] Legislators must wonder if the effort will be effective. The kind of precision the courts apparently desire is time consuming, as the whole code must be overhauled. Minor adjustments have been rejected.[696] Of course, legislatures are busy with many other matters, as well, which may seem more pressing.

With this in mind, is there any way the courts can provide justice in this area? Surely, one who would intentionally beat a fetus to death must be deterred from such conduct. The answer lies in the nature of the born-alive rule itself. The born-alive rule is based on medical limitations and is rooted in the common law. The medical proof problems are largely gone. The question remains whether the legislatures intended to incorporate in their statutes the common law meaning of terms as a static concept or as a dynamic concept. Did the term "person" or "human being" in the statute mean whatever the common law would incorporate therein when applied, or what it meant at the time passed, even if based on changed scientific facts?

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[690] *Cass*, 392 Mass. at 801, 467 N.E.2d at 1326. The principle is the same as the presumption that the legislature adopted common law definitions extant at the time a statute was promulgated.

[691] State v. Soto, 378 N.W.2d 625, 629-30 (Minn. 1985).

[692] *Id.* at 630.

[693] *Id.*

[694] Minnesota, likewise, cites *Keeler* for this argument. *Id.*

[695] *See supra* text accompanying notes 626-35.

[696] *Id.*

The principle was established in *Bonbrest* that "[t]he law is presumed to keep pace with the sciences . . . ."[697] Every state has adopted that principle by allowing a tort action for prenatal harm.[698] If such a presumption is at work, then the legislative intent must be to adopt a dynamic concept of the common law. In other words, the definition under the presumption would be one based on current legal and scientific understanding, not that of hundreds of years past, which is no longer appropriate. Even "code states" use common law definitions of terms not defined in the code. These definitions should be allowed to develop with the common law, and not be frozen in time because a legislature chose to use them. Of course, the courts should not violate the clear intent of the legislature,[699] but where the legislature has not precluded reasonable development of the law, it should be allowed.

There is a clear distinction between the judicial actions in *Roe* and in *Cass*. In *Roe*, the Supreme Court was interpreting the Constitution, which historically has entailed an analysis of the intent of the framers of the original document or the drafters of its amendments. The Supreme Court had no other legitimate authority than to perform such analysis. It was not authorized to create law as a common law court. In *Cass*, the court was acting properly within the common law tradition. Thus, for a common law court, it is wholly appropriate to apply the principle of keeping pace with science. When courts in code states employ common law interpretations of terms left undefined by the legislature, that, too, is a proper function of the courts.

However, when the Supreme Court in *Roe*[700] and in *Akron*[701] declared that science is the controlling factor, over the intent of the framers or judicial precedent, it has usurped the role of the framers in the same way that a common law court would if going contrary to the express intent of a legislature in enacting a statute.

For example, if a legislature has defined death as the cessation of respiration or heart function, even if science has moved to a brain activity definition of death, the court may not legitimately adopt a brain death test against the will of the legislature. The legislature alone is authorized to make such policy decisions. However, if statutory law does not define death, but employs common law definitions, the judiciary may keep pace with science. Judge-made law—as the common law is—may legitimately be altered by judges. The Constitution, of course, is not judge-made law. It may not be altered by the Supreme Court—at least not under constitutional authority.

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[697] *Bonbrest*, 65 F. Supp. at 143.

[698] PROSSER & KEETON, *supra* note 467, at 368.

[699] This was done in California and Louisiana under the guise of strict construction. *See supra* text accompanying notes 626-35.

[700] *Roe*, 410 U.S. at 149, 163.

[701] Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 434 (1983) (legislatures may not "depart from accepted medical practice").

However, within legitimate authority to construe statutes and develop common law, courts retain a duty to so construe statutes to avoid inequity. Our judicial system is based on the common law tradition, which influences even "code states." This tradition is a dynamic one, particularly suited to changing circumstances. Judicial "activism" within limits is a part of its genius. One hears cries of "judicial activism" by the dissent in *Cass*[702] and by the dissent in *Doe v. Bolton.*[703] The abortion cases, *Roe* and *Bolton*, were a dangerous sort of activism, clearly usurping the role of the legislatures, invalidating the legislative determinations of "a majority of the States reflecting, after all, the majority sentiment in those States,"[704] on the basis of a right nowhere mentioned in the Constitution, nor easily found among the shadows ("penumbras") thereof.[705]

By contrast, decisions such as *Mone* and *Cass* were a positive sort of "activism."[706] They represent the common law at work. In such situations, where the legislature has failed to act, injustice is being done, and precedents from collateral areas indicate a change is due, it is essential that the courts act. *Keeton* favorably argued for an expansion of such judicial involvement as legislatures are increasingly involved with other matters.[707]

> [T]he continuing accumulation of precedents tends to narrow somewhat the area of interstitial creativity and to increase the need for candid breaks with precedent . . . . [I]t is never a satisfactory answer to an argument for judicial creativity that the need for change is one

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[702] Commonwealth v. Cass, 392 Mass. 799, 810, 467 N.E.2d 1324, 1330 (1984) (Wilkins, J., dissenting) (calling the majority opinion an "exercise of raw judicial power").

[703] Doe v. Bolton, 410 U.S. 179, 222 (1973) (White, J., joined by Rehnquist, J. dissenting)(calling the majority opinion "an exercise of raw judicial power").

[704] *Roe*, 410 U.S. at 174 (Rehnquist, J., dissenting).

[705] *Id.* at 152.

[706] This assertion of good and bad forms of judicial "activism" is not inconsistent. An excellent concise discussion of the uses of the historical context of the due process clause in its interpretation is contained in the United States' brief in *Thornburgh*. Brief for the United States, *supra* note 35, at 25-29. One of the uses of history set forth is "to take account of developments in society and the law." *Id.* at 27. However, "the Court has always taken pains to trace its point of origin back to specific constitutional provisions by a route either influential or historical." *Id.* In *Roe*, the "connections by either route were wholly missing." *Id.* The brief continued, "The story traced by the Court does not show a steady and growing acceptance of a point of view until the practice in a few jurisdictions can be characterized as anomalous." *Id.* The decisions in *Mone* and *Cass* are of this latter type, well supported by the "historical trajectory." *Id.* at 28.

[707] Keeton, *Creative Continuity in the Law of Torts*, 75 HARV. L. REV. 463, 484 (1962).

> that could be accomplished by statute. Where a need for reform is clear but no reforming statute has been enacted, courts must choose among the unsatisfactory precedent and other rules open to judicial adoption . . . .[708]

This flexibility has made the common law system immensely practical. Since legislators cannot foresee every possible situation when enacting a law, there remains need for judicial interpretation.

The Massachusetts Supreme Judicial Court comprehended the need and correctly asserted its right and duty, in such a situation, to interpret the statutory term dynamically, in light of changed circumstances. It is no coincidence that the court quoted Oliver Wendell Holmes, an earlier member of the same court, who dictated the rule of no rights for the unborn:

> It is revolting to have no better reason for a rule of law than that so it was laid down in the time of Henry IV. It is still more revolting if the grounds upon which it was laid down have vanished long since, and the rule simply persists from blind imitation of the past.[709]

Thus, Massachusetts has come full circle. Whether others will follow is unclear. What is clear is that the unborn have been stripped of protection and the courts and legislatures need to act to restore it.

The protection which was afforded the unborn before *Roe* was primarily provided by the state abortion statutes rather than homicide laws. When the United States Supreme Court in the 1973 *Roe* and *Bolton* decisions declared the abortion laws of Texas and Georgia unconstitutional, it removed the shield around the unborn.

The protection had been in place for some time. As early as the thirteenth century in England, the killing of a quickened[710] fetus was a homicide, according to a contemporary commentator, Henry de Bracton.[711] William Blackstone noted this view, along with the subsequent view of Edward Coke, that such an act was only a "heinous misdeme[a]nor."[712] In 1803, the Miscarriage of Women Act was promulgated in England, increasing the crime for willful killing of a fetus to a felony and pushing protection back to quickening.[713]

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[708] *Id.*

[709] Commonwealth v. Cass, 392 Mass. 799, 805-06, 467 N.E.2d 1324, 1328 (1984) (quoting Holmes, *The Path of the Law*, 10 HARV. L. REV. 457, 469 (1897)).

[710] The law has historically protected the unborn from the beginning of life, as understood by the science of the day. This protection was pushed back to conception with the discovery of cell development in the early nineteenth century. *See supra* note 538.

[711] 2 H. BRACTON, ON THE LAWS AND CUSTOMS OF ENGLAND 341 (S. Thorne ed. 1968) (cited in *Roe*, 410 U.S. at 134 n.23).

[712] 1 W. BLACKSTONE, COMMENTARIES 129-30.

[713] LORD ELLENBOROUGH'S ACT, 1803, 43 Geo. 3, ch. 58, §§ 1-2.

The United States followed the English pattern.[714] In 1821, Connecticut prohibited causing the miscarriage of a quick child.[715] New York in 1828 extended the protection to those not yet quickened.[716] Most states followed suit with felony statutes protecting even the unquickened.[717] Even though penalties were increased over time, legislators were apparently affected by the born-alive rule, resulting in "a gross disparity in the protection of potential life and of continued life."[718] Still, criminal prosecution and penalties were generally available, especially for willful feticide, until the abortion statutes were declared unconstitutional by *Roe* and *Bolton*.[719] While *Roe* applied only to consensual abortions, it removed the abortion statutes leaving the unborn without protection. Although the states had already expressed their intent to protect the unborn from attack by the criminal abortion statutes, the courts have been generally unwilling to further this intent by applying the legislative intent when interpreting homicide statutes. Since the legislatures have been slow to act, the unborn may be killed willfully, without fear of criminal sanctions, in most jurisdictions.

Perhaps the best hope for fetal protection in the criminal area lies in comprehensive legislation to protect the unborn in non-abortion contexts. Three states are leading the way in this area. In 1987, North Dakota enacted such a comprehensive statute,[720] joining Minnesota[721] and Illinois.[722] In 1987, the Eleventh Circuit declared a Georgia feticide statute as constitutional and not conflicting with *Roe*. The criminal defendant, Smith, shot a pregnant woman and killed her unborn child.[723] He contended the feticide statute was unconstitutional "because there [was] no unlawful taking of human life, and because the statute contradicts . . . *Roe*."[724] The court declared the first contention "frivolous" and the second "without merit."[725] The fact that *Roe* declared a fetus not to be a "person" was "immaterial" where the state's interests did not conflict with a woman's right to abort.[726] In 1987, in the case of *State v. Wickstrom*,[727] the conviction of a man who beat and kicked a pregnant woman's abdomen, causing fetal death, was upheld under the state's criminal abortion law.[728] Such prosecutions may be possible elsewhere, but the need for comprehensive legislative action is clear.

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[714] Parness, *supra* note 462, at 108.

[715] *See* J. MOHR, *supra* note 425, at 21 (citing CONN. STAT. tit. 22, §§ 14, 16, at 152, 153 (1821)).

[716] *Id.* at 26-27 (citing N.Y. REV. STAT. pt. IV, ch. I, tit. II, §§ 8, 9 at 550).

[717] Parness, *supra* note 462, at 109.

[718] *Id.*

[719] *Id.* at 110.

[720] N.D. CENT. CODE § 12.1-17.1 (Supp. 1987).

[721] *See, e.g.*, MINN. STAT. § 609.

[722] *See, e.g.*, ILL. REV. STAT., ch.36, § 9-1.1.

[723] Smith v. Newsome, 815 F.2d 1386, 1388 (11th Cir. 1987).

[724] *Id.*

[725] *Id.*

[726] *Id.* at 1388 & n.2.

We see then, that in the criminal setting, *Roe's* denial of personhood to the unborn violated the principles of stare decisis by creating instability, promoting logical inconsistency, and inhibiting predictability and fairness. It destroyed legal protection for unborn children from homicide and inhibited the growth of alternative protection. Such inhibition was not mandated by *Roe*—which recognized the state interest in potential life where the mother's privacy rights do not conflict—but it was inevitable, from the shoddy reasoning and inadequate protection of the unborn in *Roe*, that other courts would follow its lead.

5. *Laws relating to respect*

Recognition of the dignity of human life is important to create a climate where life is respected and, thus, not readily taken. Some states have passed laws promoting this dignity for the unborn. These laws are in keeping with *Roe's* recognition of the state interest in protecting "potential" life.[729] The laws take two forms. First, some statutes relate to the humane disposal of fetal remains. Second, other statutes proscribe fetal experimentation, except to preserve fetal life.

The first type of statute, requiring humane disposal of fetal remains, has been adopted by a number of states.[730] Such a statute was overturned for vagueness in *Akron*.[731] The *Akron* Court found that a "decent burial" might be intended, rather than prevention of "mindless dumping" as the City of Akron argued.[732] However, in *Akron*, the Court left open the possibility of clear legislation which did not burden the mother's right of privacy.[733]

In *Leigh v. Olson*,[734] a district court overturned a statute requiring the woman seeking abortion to select a method of disposal, even though one choice was to let someone else decide.[735] The court found this to be too great a burden on the privacy right. No financial cost need have been involved and the state had a legitimate interest in promoting respect for life, including an aborted fetus.[736] However, in the court's mind, the psychological burden proved too great. There is, however, substantial room here for the states to promote the dignity of the fetus.[737]

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[727] 405 N.W.2d 1 (Minn. App. 1987).

[728] *Id.* at 10.

[729] *Roe*, 410 U.S. at 162.

[730] Parness, *supra* note 462, at 102 & n.12.

[731] *Akron*, 462 U.S. at 451.

[732] *Id.*

[733] *Id.*

[734] 497 F. Supp. 1340 (D.N.D. 1980). *Cf.* Planned Parenthood Ass'n v. Cincinnati, 822 F.2d 1390 (6th Cir. 1987); Hodgson v. Minnesota, 827 F.2d 1191 (8th Cir. 1987), *reh'g granted and opinion vacated*, 835 F.2d 1545 (8th Cir. 1987), *reinstated and (en banc) reh'g granted*, 835 F.2d 1546 (8th Cir. 1987), *reversed*, 853 F.2d 1452, *petition for cert. filed*, 57 U.S.L.W. 2105 (U.S. Feb 3, 1989).

Fetal experimentation has been barred by some states, unless it would save fetal life.[738] According to one commentator, such statutes "suggest that in contemporary American society, the fetus is sometimes accorded the same dignity as a human being born alive."[739] Such protection reflects "significant sentiment" on the part of legislators that the unborn are entitled to respect.[740]

The fetal disposal and experimentation statutes reflect a respect for the unborn which is out of step with the approach taken in *Roe*. Thus, despite the dictates of *Roe*, the people through their elected representatives continue to express their belief in the essential humanity of the unborn.

6. *Summary*

The holding of *Roe* has been shown to be out of step with the rest of the law as it relates to the unborn. The long legal history of fetal rights has been one of significant and expanding scope. The development of medical technology has solved problems of providing proof which existed in former centuries. This has led to a dramatic turnaround in tort law. However, *Roe* has inhibited this growth in the area of criminal protection by stripping the fetus of personhood and the protection of the abortion laws. The inhibiting effect of *Roe* flies in the face of logic, medical technology and the consistency principles of stare decisis.

While *Roe* and its progeny offer little protection to the postviable fetus,[741] other areas of the law offer protection back to conception and even before. These protections in other areas are much stronger than the weak protection offered in *Roe*. Clearly *Roe* is out of step with the

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[735] *Leigh*, 497 F. Supp. at 1351-52.

[736] Parness, *supra* note 462, at 146.

[737] *Id.*

[738] *Id.* at 102 (giving examples in Louisiana, Illinois, and the report *National Comm'n for the Protection of Human Subjects of Biomedical and Behavioral Research, U.S. Dep't of Health, Educ. & Welfare, Report and Recommendations: Research on the Fetus* 61-62, 67, 74 (1975)).

[739] Parness, *supra* note 462, at 102.

[740] *Id.*

[741] The "mother's health" exception has been interpreted very broadly.

Questions and Answers for the Record Submitted by Loretta P. Finnegan, M.D., Associate Director, Office for Treatment Improvement, Alcohol, Drug Abuse and Mental Health Administration, Public Health Service, Department of Health and Human Services, Rockville, MD

QUESTION #1: Where are we in terms of the trends in crack use? Will we see a sharp reduction in the increase in crack use, have we peaked, or are we looking at the tip of the iceberg?

ANSWER #1: In spite of the fact that the National Institute on Drug Abuse (NIDA) Household and High School Senior Surveys have shown a decline in drug use in the general population, the Household Survey also showed an increase in the number of heavy cocaine users (e.g., using drugs 50 times or more in the past year), including those who use crack. The 1989 High School Senior Survey has shown that the use of crack (the smokable form of cocaine that comes in chunks or rock form) has not shown as large a decline as did powdered cocaine, but the investigators report that the movement seems to be in the downward direction.

Among high school seniors, the proportion having used any crack in their lifetime fell from 5.4 percent in 1987 to 4.7 percent in 1989, and the proportion using any in the past year fell from 3.9 percent in 1987 to 3.1 percent in 1989. Current use--use in the past 30 days--has remained fairly stable over this interval at 1.3 percent and 1.4 percent, respectively.

Drug use is still at epidemic proportions. In many sections of the country, the use of crack is especially prevalent. The reduction of crack use in those communities that have been hardest hit by this epidemic is likely to be at a slower rate than the general population. It is encouraging to note however, that the escalation in cocaine related emergency room calls has abated, with the trend leveling off in 1989.

New substance abuse research, prevention, and treatment initiatives, targeted at female addicts and their children, are being implemented by NIDA, the Office for Substance Abuse Prevention (OSAP), and the Office for Treatment Improvement (OTI). The future rate of crack use by this sub-group of the population will likely correlate with the outcomes of these initiatives, and others, relative to the enhancement of treatment quality and the expansion of treatment capacity.

QUESTION #2: What is the state of knowledge regarding treatment? Do we have the "know how" but lack the national will? If this is a question of national will, what is the appropriate role for the different levels of government: Federal, State, and local.

ANSWER #2: Our knowledge about what works in drug abuse treatment is expanding. At the Federal level, the Office for Treatment Improvement and the National Institute on Drug Abuse (NIDA), components of the Alcohol, Drug abuse, and Mental Health Administration, Department of Health and Human Services, are committed to providing the national leadership necessary to improve the drug abuse treatment system and to further research efforts to expand our knowledge regarding treatment for female addicts and their children.

NIDA research on the effectiveness of various modalities of drug abuse treatment has shown that drug abuse treatment: 1) reduces illicit drug use and criminal behavior: and, 2) improves social and occupational functioning. This research also has demonstrated that the rate of seropositivity for HIV infection among IV drug abusers is lower for those in methadone treatment. Studies of methadone treatment have shown that program leadership, staff morale, staff stability, comprehensiveness of services, and adequate methadone dose levels are all important factors in program success. Generic drug abuse treatment approaches have been applied in testing crack cocaine users. However, we still have much to learn about how to attract and retain these individuals in treatment.

Research on the development of new medications for use in the treatment of drug abuse is currently focusing on a number of drugs which show promise. These include clonidine, LAAM, and buprenorphine for the treatment of narcotic addiction, and desipramine, flupenthixol, carbamazapine, verapamil, diltiazem, and bromocriptine for the treatment of cocaine addiction.

Studies of non-pharmacological treatment techniques have shown that methadone patients with psychiatric disorders may show greater improvement with psychotherapy in addition to drug counseling; that the skill level and other individual characteristics of drug abuse counselors and psychotherapists are correlated with outcomes in the treatment of opiate abusers: and that there is a correlation between the severity of psychiatric disorders and drug abuse treatment outcomes.

Recent increases in Federal spending should improve treatment outcomes by: 1) increasing the availability of treatment in general as well as the availability of specific treatment services: and 2) by providing new knowledge regarding the specific factors affecting treatment outcomes.

As our research base on what works in treatment expands, this knowledge must be transferred to the clinical field in order to improve the skill level of both individuals providing treatment as well as drug treatment program directors. This should include not only educating medical and social service professionals in state-of-the-art treatment knowledge, but in the pharmacology of drugs as well.

In addition to the research efforts, the Alcohol, Drug Abuse, and Mental Health Services Block Grant provides funds to the States for treatment services and the States, in turn, provide funds to local treatment programs. The Federal, State, and local levels of government need to collaborate in order to ensure that: 1) quality treatment is available; 2) advances from research are transferred into practice; and 3) continued efforts are made to improve the nation's drug treatment system.

Comprehensive Statewide Substance Abuse Service Plans, not currently a Federal requirement, are being instituted on a voluntary basis by OTI with participation by the National Association for State Alcohol and Drug Abuse Directors, and will both facilitate intergovernmental collaboration and further promote the national will, which does exist, to improve treatment services.

QUESTION #3: Given the increase in treatment monies going to the states can we expect to see more treatment options for pregnant addicts in the near future? Can we expect to see more successful treatment strategies given the number of OSAP and NIDA research grants?

ANSWER #3: Given the increase in treatment resources, we can expect to see more successful treatment strategies as an outcome of OSAP and NIDA demonstration programs. The original High-Risk Youth demonstration projects are nearing completion (some have already finished) and OSAP has been able to learn general lessons regarding indicators of successful prevention programs that include: 1) meeting the primary needs of the client (e.g. food, housing, physical safety, stable income, and employment) first; 2) ensuring access to culturally acceptable and accessible sites; 3) providing a comprehensive array of services; 4) providing "user friendly" services; 5) providing a continuity in staff services to clients; 6) concentrating resources for a maximum programmatic impact; 7) targeting risk and resiliency factors that can be changed; 8) narrowing program focus as youth get older; 9) providing stable, caring adult role-model/surrogate parent; 10) training parents in communications and limit-setting skills while providing a skill-building program for youth; 11) involving the school system; 12) providing appropriate staff role models; 13) training and recruiting committed staff; and 14) implementing consistent community, neighborhood, and school policies regarding drug use.

Other lessons OSAP has learned from their experience with providing high-risk families and children with health and social services, education, child care, and family supports are:
1) treatment that works for one segment of the population is not necessarily effective for all segments of the population; 2) simple didactic educational programs aimed at informing and changing behaviors don't work and may increase likelihood that program participants will use illicit substances; 3) peer counselor programs, teen theatre, and puppet programs do not have uniformly positive effects; 4) parent involvement programs, "Just Say No" Clubs, mass media campaigns, and activity programs are less effective when provided alone, without addressing the comprehensive service needs of the family.

OSAP program evaluation and NIDA research will continue to build upon these findings and transfer the knowledge to the field. With regard to OSAP's Pregnant and Postpartum Women Demonstration Program, it is still too early in the implementation of this initiative to discuss successful treatment strategies for this population. However, we expect information on process evaluation to become available from each grantee as their grants expire. The first awards under this program were made in September 1989. A contract to evaluate these projects is under development. Availability of the first treatment outcome data is targeted for October, 1990. Increased quantity, reliability, and validity of this outcome data will occur over the following 2-4 years.

In addition to the OSAP efforts, NIDA is researching drug abuse in pregnant and postpartum women, in hopes of preventing drug abuse before conception and to intervene with effective therapeutic programs for women that lessen the developmental problems of children born to addicted mothers.

NIDA is currently participating in a coordinated effort with the Association for Medical Education and Research in Substance Abuse (AMERSA) and Brown University Center for Alcohol and Addiction Studies, to train physicians, including practitioners in obstetrics and pediatric medicine, to diagnose and treat the multiple problems related to drug dependency.

Furthermore, organizations such as the American Society of Addiction Medicine, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists are involved in providing education to their members to assist them in identifying and treating individuals addicted to drugs. The American Society of Addiction Medicine also provides physician certification in the area of substance abuse.

Locating, admitting, and retaining addicted pregnant women in drug treatment and providing them with clinical services presents numerous difficulties. To address these issues, NIDA supports a number of studies that aim to eliminate existing barriers to treatment through the development of referral systems and intensive community outreach programs. NIDA also supports a major research demonstration program to provide more effective drug abuse treatment, clinical, and social support services to female addicts and their children.

QUESTION #4: What needs to be done and what are we doing now?

ANSWER #4: NIDA studies have found that we need to increase accessibility to treatment and provide a comprehensive continuum of services for drug addicted individuals. Many women addicted to drugs do not possess essential life skills. As part of their treatment, they require comprehensive services including: 1) outreach strategies to engage them in treatment; 2) appropriate matching of patients to treatment to improve treatment outcomes; 3) provision of child care at treatment sites; 4) job training; 5) assistance in locating stable housing; and other such help. Substance abuse prevention education programs for children of mothers in treatment are also needed.

In FY 1989, NIDA funded 10 demonstration grants to provide and assess a variety of comprehensive treatment programs for addicted pregnant and postpartum women. The programs expand beyond the traditional medical-based addiction programs to include components such as obstetrical care specific to drug-induced medical complications, psychotherapy or individual/group counseling, communication skills and parent skills training, educational/ vocational training, drug-free safe housing, long-term outreach caseworker assignment, and self-help and peer group support activities. It is estimated that up to 3,000 women, and nearly half that number of infants and young children, will receive treatment and have a broad array of services made available to them.

NIDA is also supporting projects to deal specifically with women at risk for HIV infection. Two of these projects provide services and evaluate the efficacy of services to pregnant addicts. These projects are seeing or have seen more than 2,300 women.

Further, as part of ADAMHA's commitment to improving medical services in general for substance abusers in treatment, and for pregnant and postpartum women and their infants in particular, Dr. Loretta Finnegan has been appointed as OTI's Associate Director. Dr. Finnegan will also hold the title of Associate Director for Clinical and Medical Affairs in the Office for Substance Abuse Prevention. Dr. Finnegan brings an internationally recognized expertise in the provision of treatment services of pregnant and addicted women and their children to OTI and OSAP. As part of her duties with OTI and OSAP, Dr. Finnegan continues to speak frequently at national and international meetings to share her expertise on what works in the treatment of addicted women and their children.

Dr. Finnegan is a former grantee of the National Institute on Drug Abuse (NIDA). While at OTI and OSAP, Dr. Finnegan will provide a guiding hand in policy development to ensure that state of the art treatment approaches are implemented for this population. The nurturing of Dr. Finnegan's interest in researching and developing clinical approaches for pregnant addicts and their neonates, supported by NIDA, and her current joint appointment at the service components of ADAMHA is an example of the synergism between our research and treatment improvement efforts at ADAMHA.

OTI's new discretionary demonstration programs will also directly or indirectly serve female addicts and their children. These programs are: 1) Cooperative Agreements for Drug Abuse Treatment Improvement Projects in Target Cities; 2) Model Comprehensive Treatment Programs for Critical Populations; 3) Model Drug Abuse Treatment Programs for Correctional Settings; and 4) Model Drug Abuse Treatment Programs for Populations Diverted from Incarceration within the Criminal Justice System.

The first of these, "Target Cities", also known as "Treatment Grants to Crisis Areas", provides financial and technical assistance to State-selected urban areas that have been identified as having a high prevalence of drug abuse. The program supports activities designed to diminish the barriers to interagency coordination and cooperation that exist in the drug treatment system: improve the delivery, accessibility, and success of treatment services; and strengthen the drug treatment infrastructure.

Six "Target Cities" grants are expected to be awarded in FY 1990. It is anticipated that the average amount of an award under this program will be $5 million. By combining funds from these grants with State and local resources, it is believed a significant impact can be made on the drug epidemic in target cities.

OTI's second new program, "Model Comprehensive Treatment Programs for Critical Populations", is expected to fund approximately 47 projects in FY 1990. These grants will support improvements to existing treatment program and treatment systems that are geared toward the following critical populations: 1) racial and ethnic minority populations; 2) adolescents; and 3) residents of public housing projects. Rural, homeless, and comorbid substance abusing populations are also a focus. Fundable program components include, but are not limited to, the following: 1) enhanced outreach methods; 2) provision of on-site primary medical care and provision of acute medical care; 3) staff training; 4) health and AIDS education; 5) life skills counseling; 6) educational and vocational counseling; 7) enhanced aftercare; 8) psychological and psychiatric services for comorbid patients; and 9) facility improvements.

Next, OTI has announced two grant programs in FY 1990 to serve patients involved in the Criminal Justice System. OTI will fund demonstrations in the following areas: 1) improved coordination of all facets of the criminal justice system (i.e. courts, jails, social services, and treatment systems) in target cities; 2) improved policies and procedures for diversion of arrestees into treatment in lieu of incarceration; and 3) on-site provision of drug treatment services in jail and prison settings. Approximately 14 grant awards are expected under these two programs in FY 1990.

Under its Criminal Justice System treatment improvement initiative, OTI will place program priority in FY 1991 on developing model drug treatment programs in prisons. The goal of this demonstration project is to create a new standard for comprehensive drug abuse treatment in prisons utilizing all of the research, experience, and medical knowledge related to treatment of criminal offenders that has been acquired over the past sixty years. A secondary goal is to use the drug treatment programs as a research-based training facility for treatment and corrections administrators.

All of OTI's new discretionary grant recipients will participate in a national evaluation of their programs designed to determine their impact on both individuals treated, and the community as a whole. These evaluations will also spotlight effective treatment methods that can be replicated nationally.

The "Anti-Drug Abuse Act of 1988" expanded OSAP'S mandated activity related to pregnant and postpartum women and their infants. Thus, in September 1989, OSAP funded its first Model Projects for Pregnant and Postpartum Women and their Infants Service Demonstration Grants. The model projects are run by public and private, profit and non-profit organizations; are located in community, inpatient, outpatient and residential settings; and focus on education, prevention, and treatment of women within the framework of a comprehensive, holistic continuum of care approach.

OSAP supports service demonstration projects that propose promising models or innovative approaches to prevent or minimize fetal exposure to illicit drugs and alcohol and increase the availability and accessibility of services to these populations. Special priority is given to projects addressing the use of cocaine, including crack cocaine, and low income women. Applications may propose projects to coordinate existing services and/or new or expanded services. They are also encouraged to develop services involving health, education, voluntary and other relevant community-based organizations and service systems. Within a year, OSAP will have preliminary analysis of management information data, site reports, and other data on the first 30 projects that have been in operation since 1989.

OSAP currently funds 46 grants under the pregnant and postpartum women and their infants initiative. By the end of FY 1990, a total of about 118 new demonstration grants are expected to be funded. The grants average $258,261 per year for 3 to 5 years. It is estimated that the first group of grantees will reach about 60,000 women. Direct care will be provided to approximately 7,000 women. The total FY 1989 actual obligation for the program was $4.6 million. The program budget is $32.5 million in FY 1990, and the President's Budget Request for this program is $37.6 million in FY 1991. Additionally, OSAP utilizes other program funds to address this population which brings the FY 1990 appropriation to $35 million, and the President's Budget Request for FY 1991 to $42.8 million.

OSAP and the Office of Maternal and Child Health (OMCH) of the Health Resources and Services Administration (HRSA) have entered into an interagency agreement to support funding of the demonstration grant program to develop Model Programs for Pregnant and Postpartum Women and Their Infants. This collaborative effort allows the OMCH to provide expertise in the development of perinatal health components that is blended with OSAP'S expertise in prevention/early intervention services with high risk substance abusing populations. OMCH has lead program responsibility in the Public Health Service (PHS) for assuring prenatal care for women and reduction of infant mortality.

OSAP is also working with the Administration on Children, Youth and Families (ACYF) of the Office of Human Development Services to expand and coordinate health, social services, and substance abuse program efforts. ACYF is responsible for implementation of the Abandoned Infants Program authorized in 1989 and funded in FY 1990. Demonstration grants and other activities are planned to prevent abandonment of infants or young children, and to address the needs of those who are, or might be, abandoned, especially those infants born to mothers who are addicted to drugs, who have AIDS, or are HIV positive. In its FY 1991 Budget Proposal, it has been requested that ACYF receive an additional $4 million for the child welfare research and demonstration program to be used specifically to fund innovative projects that demonstrate ways to meet the immediate nonmedical needs of infants born to crack-cocaine using mothers and HIV-infected babies.

In addition to individual initiatives, OSAP has an ongoing working relationship with other ADAMHA components including -- The National Institute on Alcohol Abuse and Alcoholism (NIAAA), NIDA, and OTI -- To promote maximally effective efforts in the areas of research and comprehensive services for pregnant and postpartum women and their infants. These linkages are further described at Attachment 1, "What Are The Linkages Between NIDA, OSAP & OTI And Other Federal Components?".

WHAT ARE THE LINKAGES BETWEEN NIDA, OSAP & OTI AND OTHER FEDERAL COMPONENTS?

OSAP has joined other federal government agencies in developing and promoting effective comprehensive approaches to prevention. The problems of alcohol and other drug abuse prevention must be a multiagency effort. The current anti-drug abuse effort includes 11 cabinet secretaries and approximately 33 agencies that carry out both supply and demand reduction programs. We have formed partnerships to enhance opportunities for comprehensive approaches to prevention and early intervention. These partnerships are important not only to the success of OSAP's initiatives but to our partners missions and goals.

Between OSAP and OTI, it was agreed that OSAP would take the lead with this population (PPWI). Any information learned from OSAP's demonstrations projects is immediately shared with OTI and the Institutes. OSAP and OTI are planning to begin scheduling regular meetings to discuss policy development and to share knowledge about PPWI.

There are direct linkages between the NIDA, OSAP & OTI. NIDA's programs for PW include research on the effects of maternal drug abuse on infant development, and research demonstrations to develop new therapeutic approaches or correct deficiencies in existing clinical programs designed to treat drug using women of child-bearing age as well as PPWI. Knowledged derived from these research findings are used to develop OSAP's demonstrations projects and directly feeds into OTI's operational, service delivery and/or field knowledge activities. Conversely, OSAP's community-based demonstration models of education, prevention, and/or treatment for substance using PPWI which are designed to promote coordinated participation of multiple organizations in the delivery of comprehensive services for these women, in many instances, serve as a basis for NIDA's research and OTI's activities. Of course, the provision of financial assistance to specialized treatment programs for substance using PPWI by OTI has a direct correlation to the activities of OSAP and NIDA.

FEDERAL EFFORTS AFFECTING DRUG EXPOSED CHILDREN

Public Health Service Programs and Activities

- OSAP/MCH Pregnant and Postpartum Women and Their Infants Demonstration Projects
- OSAP Sponsored Conferences
- OSAP Training Efforts
- NIDA Demonstration Projects
- NIDA/NIAAA Health Professions Education Program
- NIDA Research
- NIDA Technical Reviews
- BHCDA Community and Migrant Health Centers
- HRSA Pediatric AIDS Health Care Demonstration Grants
- HRSA SPRANS Grants
- ADMS Block Grant Set Aside
- Miscellaneous Evaluations
- Office of Treatment Improvement Activities

Human Development Services Programs and Activities

- Foster Care and Adoption Assistance (Title IV-E)
- Child Welfare Services (Title IV-B)
- Crisis Nursery Program
- University Affiliated Program Projects
- Child Abuse and Neglect Prevention
- Head Start
- Community Child Development Program
- Coordinated Discretionary Grants
- Abandoned Infants Assistance
- Social Services Block Grant
- HDS/MCH Planned Conference
- Miscellaneous Evaluations

Family Support Administration Programs and Activities

- Aid to Families With Dependent Children (AFDC)

Other HHS Programs and Activities

- Medicaid
- SSI Disabled Children
- Centers for Disease Control Research
- Secretarial Access Initiative
- Secretarial Family Strengths Initiative
- Access Initiative Conference
- Inspector General's Reports on Boarder Babies and on the Impact of Crack on Child Welfare Systems

Elsewhere

- National Commission to Prevent Infant Mortality
- GAO Study of Care Costs
- Department of Education drug use prevention and early intervention programs

Question #8: What do we know as far as the research literature about the effectiveness of different modalities of treatment for drug abusing pregnant women? Is this literature well documented or is it currently emerging given NIDA and OSAP and OTI research monies?

Answer #8: Preliminary information on what works best with the pregnant and postpartum women population will be available within the next two years. NIDA is conducting research demonstrations to improve or develop new therapeutic approaches in existing clinical programs designed to treat drug abusing women of child-bearing age as well as pregnant women, postpartum women, and their infants.

There is increased awareness of the wide array of potential consequences of maternal drug abuse to offspring so that the elimination of, or any reduction in, the use of illicit drugs as a result of enrolling and retaining women who are pregnant or are of child-bearing age in a comprehensive drug treatment program can forestall these potentially harmful consequences. Because many adolescent or young adult women are difficult to place and maintain in traditional drug abuse treatment programs, extensive community outreach and retention efforts will help to eliminate existing barriers to treatment for these women.

While some literature on the subject of what works with this population exists, current research on new strategies for treatment and on models for treatment intervention and prevention should provide substantive additional information that will allow treatment for female addicts and their children to be further enhanced. These research efforts include:

1) The In Utero Drug Exposure Survey, which will be in the field in late 1990 or early 1991, will collect data on the prevalence of drug use during pregnancy for the whole country, as well as for different geographic areas and population subgroups. The Survey will provide estimates of the number of babies exposed to drugs during pregnancy and assess the association of drug exposure with certain outcome indicators such as birth weight and length of stay in hospital. Data will be collected from approximately 6,000-8,000 pregnant women who deliver their infants in hospitals.

2) The questionnaire proposed for the 1990 National Drug and Alcoholism Treatment Unit Survey (NDATUS) includes several items related to pregnant and post-partum women. Information will be obtained on providers offering specialized programs for pregnant users and those offering child care services. An estimate of the number of pregnant clients will be obtained.

3) The Drug Abuse Services Research Survey questionnaire includes questions on drug dependent pregnant women, such as:

   - Whether the drug treatment facility accepts pregnant women;

   - Whether any priority for admission is given to pregnant women on facility waiting lists;

- o The kinds of special services available to pregnant women with drug problems. A checklist includes prenatal care, birthing, parenting skills, child care services, and other.

4) Data has been collected through the NIDA AIDS demonstration projects at 43 sites around the country. To date, data has been collected on about 5,000 women, including about 400 pregnant women. Data includes demographic characteristics, risk behaviors, family responsibilities, health status, and AIDS knowledge.

The Department of Health and Human Services will also support further research to better understand this population through the Center for Disease Control's Maternal and Infant Health Survey and Longitudinal Follow-Up.

It should also be noted that NIDA has funded several model treatment programs for this population. These programs include:

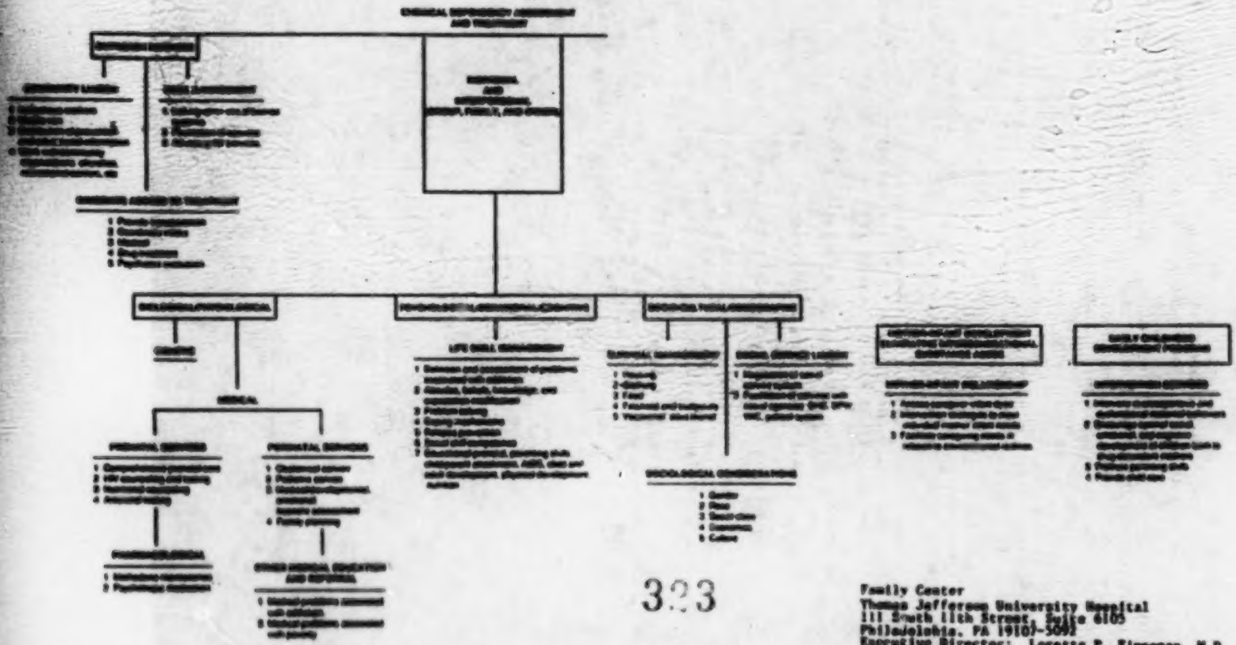
- o The Family Center, Jefferson Medical College, Philadelphia (see Attachment 2: Family Center Schema for Treatment of Drug Dependency in the Perinatal Period and Aftercare);
- o FAAN Program, Flower 5th Avenue Hospital, New York City;
- o Hutzel Hospital Program, Detroit;
- o Operation PAR, Pinnellas County, Florida.

The FAAN Program, Hutzel Hospital, and Operation PAR were all receiving funding from NIDA in FY 1976. The Family Center was receiving NIDA funding as far back as the early 1970's.

More recently, programs in San Francisco, Los Angeles, Seattle, Chicago, Miami, and Boston have begun to look at treatment and prevention for female addicts and their children. The Albert Einstein Medical Center in New York City is also particularly noted in this regard.

Attachment #2

SCHEMA FOR TREATMENT OF DRUG DEPENDENCY IN THE PERINATAL PERIOD AND AFTERCARE



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QUESTION 86: Can we compare outcomes and effectiveness given outpatient vs. inpatient treatment approaches?

ANSWER 86: Outcomes can be compared across different types of treatment if the patients are randomly assigned to each modality. Studies that have used prospective assignment have found that for certain clients, especially those with serious psychiatric comorbidity, some types of treatment produce better outcomes than other types. However, treatment assignment is difficult in practice because the assigned treatment may be unavailable, clinically unacceptable, or not suited to patient needs; or the patient may strongly prefer a different type of program. Even with matching, outcomes are heavily dependent upon other factors, such as the amount of time spent in treatment, during-treatment performance, social adjustment of the patient, and psychological motivation to change.

According to NIDA's Drug Abuse Reporting Program (DARP), conducted from 1969-74, the most important factor necessary for a favorable outcome is the amount of time spent in treatment. DARP defined a favorable outcome as no illicit drug use and no criminal activities. A second project, the NIDA-funded Treatment Outcome Prospective Study (TOPS), provided convincing evidence that criminal justice referrals do as well or better than other patients in drug treatment. Criminal justice involvement helped to retain patients in treatment, and drug use and criminal activity decreased substantially for those with a legal status. Many referrals had not been treated previously and were not heavily involved in drug abuse. By providing an early interruption of criminal and drug abuse careers, criminal justice referral to treatment produced substantial long-term benefits in reducing both crime and drug abuse among treated offenders.

NIDA's current Drug Abuse Treatment Outcome Study (DATOS), is in the first stages of implementation. This study, which is the first large scale study of treatment outcomes since the implementation of Block Grant funding, will consist of multi-year investigations of drug abuse treatment effectiveness based on a nationwide purposive sample of five broad categories of drug treatment programs (e.g., short and long-term methods of methadone maintenance, short and long-term residential treatment; and outpatient drug-free treatment). The goals of DATOS are:

1) To describe current drug abuse treatment populations in terms of demographic characteristics, psychological variables, sociocultural variables, treatment history, tenure, and during-treatment behaviors;

2) To characterize existing treatment modalities and treatments within those modalities;

3) To define the treatment process so that relationships between client variables, treatment process variables, significant non-treatment variables, and outcomes can be identified;

4) To analyze treatment outcomes in order to evaluate treatment

effectiveness and to determine the relationship between treatment outcomes and important client, program, and treatment factors; and

5) To conceptualize and measure impairment, and to determine the relation between impairment and outcomes during and after treatment.

Further, their are several issues that must be taken into consideration in determining what treatment modality will work best for each patient. While outpatient care is obviously more cost-effective when appropriate, residential treatment permits delivery of comprehensive services "under the same roof", which reduces the frequent occurrence with this population of fragmentation and inaccessibility of services. For example, the related problems of maternal and child health, parenting, substance abuse, and homelessness are addressed by the limited residential programs in existence. The programs both remove women from the destructive environments which lead to drug-dependence and limit their access to drugs. Residential care for this population has been shown to be a more cost-effective treatment alternative than incarceration, especially when the costs of placing the female addict's children in foster care is considered.

QUESTION #7: What can we expect in terms of recidivism rates? Do these rates differ by modality, age of drug user, type of drug, marital status, pregnancy status, sex, length of time abusing the drug? What cuts can be made here to inform policy makers?

ANSWER #7: In the past, variables such as the ones mentioned have not been predictive of outcomes when taken individually. Composites of these variables are more useful. For example, clients whose profiles after treatment suggest high social adjustment--defined as being married, older, better educated, better employed, with fewer arrests, and better psychological adjustment--are less likely to relapse to drug use than those with low after-treatment social adjustment. The level of physical, psychological, or social impairment appears to contribute to relapse if not treated.

It is important to note that drug dependence is by nature a chronic, relapsing disease. For the majority of those addicted to drugs such as heroin or cocaine, a single episode of treatment will not yield a "cure." Drug users may pass through cycles of drug dependence, treatment, abstinence, and relapse. Commitment to the care of individuals affected with addictive behavior over their life span is crucial. Each treatment episode may help the addict to achieve abstinence from illicit drugs, and relapse prevention programs following treatment may extend and maintain abstinence.

QUESTION 60: What is known about the etiology of drug use? Is there any research that weighs the differential importance of behavioral genetics, physiology, psychopathology, family or environment on outcome?

ANSWER 60: NIDA is developing profiles of those factors which exacerbate an individual's chances of becoming drug dependent and which may serve as predictors and identifiers of future dependence. Some of the major precursory factors which research has identified:

- Problem behavior proneness or deviance syndrome, i.e., involvement with other deviant behaviors and delinquent peers, is typically antecedent to adolescent substance abuse.
- Adolescents commonly progress through developmental stages of drug use initiation with each stage facilitating escalation to increased hard-core use of illegal substances.
- Psychopathology, sometimes in an early or premorbid stage, is frequently an antecedent concomitant of drug abuse.
- Impaired function possibly including difficulty in emotional regulation, planning, problem solving, perceptual motor function, language and information processing, coping, and difficulty in interpersonal problem solving are frequent antecedents to drug abuse.
- There appears to be a familial/genetic component to substance abuse.
- There are environmental antecedent factors which exacerbate an adolescent's risk for drug abuse including drug availability, family disruption and other factors, such as cultural norms.
- Predisposing influences also include drug factors and drug use history factors. Different drugs and different routes of administration are associated with differing abuse liabilities.

QUESTION #9: In terms of the nature of addiction, what does the research tell us about the role of individual motivation to overcome addictive behavior? In the absence of such motivation is anything likely to work? How can one develop a policy that induces personal motivation?

ANSWER #9: Motivation to change is a complex phenomenon and therefore very difficult to measure. For that reason, and because drug dependence is by nature a chronic, relapsing disorder, the subject is rarely addressed in the research literature. Many drug users pass through cycles of drug dependence, treatment, abstinence, and relapse. Patients whose expectations of treatment are at variance with the treatment they receive are less likely to do well in treatment; however, expectations become more realistic with multiple episodes of treatment and each treatment episode may help the addict achieve abstinence from illicit drugs, and relapse prevention programs following treatment may extend and maintain abstinence.

QUESTION #10: What does the drug abusing population of mothers look like? Are we talking inner city, low income, i.e. a disproportionate share of the problem is inner city, low income, or are we talking cuts across socio-economic status, geographic area, etc.?

ANSWER #10: Substance abuse among women of childbearing age tends to cut across all ethnic and socioeconomic groups. In several areas of the country, studies have shown substance abuse among upper class women.

The In Utero Drug Exposure Survey which will be in the field in late 1990 or mid 1991 will collect data on the prevalence of drug use during pregnancy for the whole country, as well as for different geographic areas and population subgroups. The Survey will provide estimates of the number of babies exposed to drugs during pregnancy and assess the association of drug exposure with certain outcome indicators such as birth weight and length of stay in the hospital. Data will be collected from approximately 5,000 women who have just delivered their infants in hospitals.

Also, the questionnaire proposed for the 1990 National Drug and Alcoholism Treatment Survey (NDATUS) includes several items related to pregnant and postpartum women, Information will be obtained on providers offering specialised programs for pregnant users and on those offering child care services. An estimate of the number of pregnant clients will be obtained.

The NIDA Drug Abuse Services Research Survey questionnaire includes questions on:

- Whether the drug treatment facility accepts pregnant women;
- Whether any priority for admission is given to pregnant women on facility waiting lists;
- Whether special services are available to pregnant women with drug problems. A checklist includes prenatal care, birthing, parenting skills, child care services, and others.

Data has been collected through the NIDA AIDS demonstration projects at 63 sites around the country. To date, data has been collected on about 5,000 women, including about 400 pregnant women. Data includes demographic characteristics, risk behaviors, family responsibilities, health status, and AIDS knowledge.

Data collected on pregnant women participating in the NIDA AIDS demonstrations reveal the following information:

- most are young (e.g., 10% under 20 years of age, 59% between the ages of 20-29);
- most are members of racial or ethnic minority populations (e.g., 50% Black, 27% hispanic);

- 54% did not graduate from high school;
- 60% are unemployed;
- 41% rely on government program for financial support;
- 30% support themselves through illegal means;
- 13% derive their income from a spouse or sexual partner;
- 60% have children living with them;
- 10% support children not living with them;
- 48% have children under 18 not living with them;
- 18% are homeless;
- 21% have spent time in jails in the six months proceeding their interview for this study; and
- overall, the majority reside in inner city neighborhoods and are poor and uneducated.

In some local studies, only inner-city residents have been interviewed, thereby skewing the data. Certain hospitals have shown a substantial number of cocaine users in the middle class population of pregnant women.

QUESTION #11

What is the role of the Federal government, including OSAP, in addressing perinatal alcohol and drug use?

ANSWER #11

- o RESEARCH
  - OSAP & OMCH
    - Evaluation of Pregnant and Postpartum Women and Their Infants (PPWI) Demonstration Grant Program
  - NIDA
    - Research Demonstration Grants
    - General Research Funds
    - In Utero Drug Exposure Survey
- o EDUCATION
  - OSAP & OMCH
    - PPWI Demonstration Grant Program
  - OSAP
    - Conference Support
    - National Training System
    - NCADI
    - RADAR
  - NIDA
    - Conferences
  - NIDA & NIAAA
    - Health Professions Education Programs
  - BHCDA
    - Community and Migrant Health Center Programs — Substance Abuse Initiative

DOE

Drug Free Schools

DOA

WIC

- **PREVENTION**

  OSAP & OMCH

  PPWI Demonstration Grant Program

  OSAP

  High Risk Youth Demonstration Grant Program
  (Specifically with Pregnant Adolescents)

- INTERVENTION

  OSAP & OMCH

  PPWI Demonstration Grant Program

  HDS

  The National Center on Child Abuse
  and Neglect
  Community Child Development
  Abandoned Infants Assistance Act of 1988
  (PL100-505)

  DOE

  Early Intervention for Children with Special
  Needs (PL 99-457)

- TREATMENT

  OSAP & OMCH

  PPWI Demonstration Grant Program

  OTI

  Treatment Improvement Grants

  ADAMHA

  ADMS Block Grant

BHCDS

Community and Migrant Health Center Program
Comprehensive Perinatal Care Initiative

HDS

Temporary Child Care for Handicapped Children
and Crisis Nursery Program

DOA

WIC

NOTE:

The Office of Maternal and Child Health had a Block Grant, $554 million appropriation FY 90, which goes to the States; the States have used this money to cover a wide range of activities at the state level.